Arizona Department of Health Services

ADHS
Independent Case Review
2002

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1. Executive Summary

Overview and Purpose of the Study

The Arizona Department of Health Services (ADHS) contracts with Regional Behavioral Health Authorities (RBHAs) covering six Geographic Service Areas (GSAs) across the State of Arizona to deliver a full range of behavioral health services.

One component of the ADHS commitment to providing high-quality services to this population is the annual independent review and quality evaluation for individuals covered by Titles XIX and XXI. The 2002 Independent Case Review (ICR) is conducted by Health Services Advisory Group, Inc. (HSAG), functioning as an independent review organization. The ICR focuses on a clinical record review designed to measure adherence to established guidelines and standards. The goal of the 2002 ICR is to establish a baseline measurement for clinical and practice outcomes. Aspects of performance which were reviewed included but were not limited to:

- Access to care
- Coordination of care with acute contractors/Primary Care Physicians (PCPs)
- Sufficiency of assessments
- Individual/family involvement
- Cultural competency
- Informed consent
- Quality clinical outcomes

Methodology

The study population consisted of adults and children enrolled in the Arizona Behavioral Health System who received a Title XIX or Title XXI service between April 1, 2002 and December 31, 2002. Those eligible must have been continuously enrolled for at least 90 days during the six months prior to implementation of the review (January 1, 2003). Individuals who received only transportation, laboratory, or radiology services were excluded from the study. There were 57,303 individuals in the eligible population.

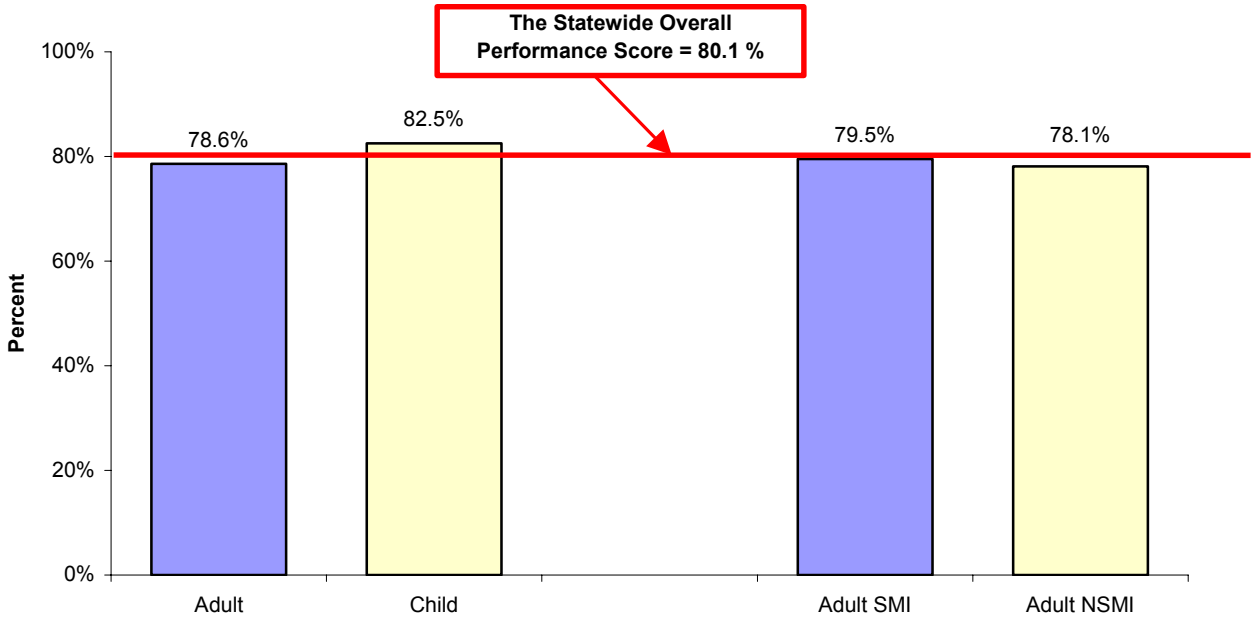
The sample cases were randomly selected at the GSA level, observing the adult/child enrollment ratio within each GSA. The Tribal Regional Behavioral Health Authorities (TRBHA) samples were likewise randomly selected from the eligible TRBHA population. The TRBHA sample size was determined as a subset of the GSA. The final sample size consisted of 1,540 cases.

To abstract data from the clinical records, a clinical chart audit tool was developed by ADHS in collaboration with HSAG and approved by the Arizona Health Care Cost Containment System (AHCCCS) (see Appendix E). The ICR abstraction tool (Appendix F) consisted of 21 standards. Minimum performance scores were established by ADHS for 20 of the standards (i.e., Standard 13 had no established performance score, and therefore, was not used in the calculation of statewide or GSA performance).

Overall Statewide Findings

The overall performance score provides an indication of how often all required processes, services (e.g., case management), or outcomes were met. Refer to page 3-3 for a discussion regarding the scoring methodology. The statewide overall performance score was 80.1 percent. The statewide performance score was 78.6 percent for the adults and 82.5 percent for the children. Additionally, the statewide performance score was 79.5 percent for SMI and 78.1 percent for non-SMI.

Figure 1-1—ADHS Independent Case Review 2002: Statewide Overall Performance Scores



Minimum Performance Scores

The table below displays the statewide results for the adult and child populations, as well as the SMI and non-SMI populations. Statewide, 10 of the 20 (or 50.0 percent) minimum performance scores were met or exceeded for the adult sample and 15 out of 20 (or 75.0 percent) minimum performance scores were met or exceeded for the child sample.

Statewide, the results for SMI and non-SMI for 15 out of the 20 standards were not statistically different.

For the SMI population, results for Standards 5, 10, 11, and 16 were statistically higher than non-SMI, while Standard 9, which considers cultural competency, was statistically lower than the non-SMI results.

Table 1-1—ADHS Independent Case Review 2002: Results of ICR Standards 1-21

#	ICR Standard	Minimum Performance Score	Statewide Results			
			Adults	Children	SMI	Non-SMI
1	Assessments are sufficiently comprehensive for the development of functional treatment recommendations.	85%	88.1%	85.3%	87.8%	88.2%
2	The types and intensity of services are provided based upon the needs identified in the individual's assessment and treatment recommendations.	85%	90.7%	91.6%	92.2%	89.9%
3	Staff actively engage the following in the treatment planning process:	85%	83.6%	88.3%	83.7%	83.5%
	a. individual		96.0%	84.4%	95.6%	96.2%
	b. family		48.3%	93.3%	54.4%	44.1%
	c. other agencies		87.7%	86.8%	87.3%	87.9%
4	Case management services are provided based on the individual's assessment and treatment recommendations.	85%	93.0%	96.0%	94.4%	92.2%
5	Outreach/follow-up occurs after:	80%	77.3%	73.2%	86.3%	70.4%
	a. discharge from inpatient		94.3%	78.3%	98.6%	87.8%
	b. discharge from residential		78.1%	83.3%	88.9%	64.3%
	c. missed appointments		72.8%	70.2%	81.0%	67.9%
	d. crisis episodes		89.6%	89.2%	93.3%	84.6%
	e. service refusal		64.2%	73.6%	75.0%	59.5%
	f. medication refusal		82.4%	80.0%	87.1%	75.0%
6	FOR DDD MEMBERS ONLY: Individuals with identified specialized service needs are referred for and receive these services.	85%	82.1%	98.0%	100.0%	78.8%
7	The individual has an assigned clinician	80%	97.2%	98.1%	97.7%	96.9%

Table 1-1—ADHS Independent Case Review 2002: Results of ICR Standards 1-21

#	ICR Standard	Minimum Performance Score	Statewide Results			
			Adults	Children	SMI	Non-SMI
8	The assigned clinician is actively involved in the oversight of the treatment.	80%	96.5%	98.0%	96.7%	96.5%
9	Individuals'/families' cultural preferences are assessed and included in the development of treatment plans.	70%	18.3%	17.9%	14.0%	20.8%
10	Individuals and/or parent/guardians are informed about and give consent for prescribed medications.	80%	53.2%	53.6%	59.1%	48.1%
11	If the individual has been prescribed anti-psychotic medication, regular assessments for movement disorders are documented.	70%	58.4%	62.1%	63.3%	50.7%
12	If the individual has been prescribed psychotropic medication and adverse reactions or side effects are noted, progress notes include documentation of follow-up actions to address adverse effects.	85%	82.1%	89.5%	85.3%	78.5%
13	If the individual has been prescribed psychotropic medication, the record includes documentation of specific target symptoms.	No Minimum Performance Score	63.2%	67.8%	63.1%	63.2%
14	The disposition of the referral from the PCP or Health Plan is communicated to the PCP or Health Plan within 30 days of receiving the request for service.	60%	69.0%	78.6%	64.3%	70.5%
15	Behavioral health care has been communicated or attempts have been made to coordinate with the PCP in the following circumstances:	60%	52.4%	56.2%	54.0%	51.2%
	a. initial assessment and treatment recommendations		63.1%	67.6%	62.0%	63.5%
	b. initiation and significant changes in psychotropic medications and significant adverse reactions		55.4%	51.4%	61.9%	49.6%
	c. results of relevant laboratory, radiology and other tests		50.9%	51.1%	54.5%	45.5%
	d. emergency/crisis admission or events		31.1%	12.5%	30.9%	31.4%
	e. discharge from an inpatient setting		27.0%	25.0%	25.0%	29.5%
	f. disenrollment from ADHS/RBHA		17.7%	28.2%	14.3%	18.2%
	g. any other events requiring medical consultation with the individual's PCP		67.5%	76.2%	70.4%	65.0%
16	There is evidence of symptomatic improvement.	80%	74.4%	83.5%	79.0%	71.5%
17	There is evidence of functional improvement.	80%	72.2%	82.2%	75.4%	70.1%
18	Service plans and/or services are revised based on progress or lack of progress in the individual's behavioral health condition.	70%	75.0%	81.4%	77.2%	73.5%

Table 1-1—ADHS Independent Case Review 2002: Results of ICR Standards 1-21

#	ICR Standard	Minimum Performance Score	Statewide Results			
			Adults	Children	SMI	Non-SMI
19	Service plans and/or services are revised based on significant changes in the individual's behavioral health condition.	70%	72.5%	77.8%	76.6%	68.6%
20	The treatment plan:	80%	95.7%	95.7%	95.1%	96.1%
	a. incorporates the identified needs of the individual		95.7%	96.2%	93.7%	96.8%
	b. includes measurable goals which address those needs		95.1%	95.3%	94.7%	95.3%
	c. describes specific action steps to reasonably accomplish the goals		96.4%	95.5%	96.8%	96.1%
21	Services are provided in a timeframe responsive to the urgency of the member's need.	85%	94.5%	95.8%	95.1%	94.1%

Standard 6 focused only on DDD sampled cases. For these DDD members, the adult population did not meet the minimum performance score of 85.0 percent, while the child population achieved 98.0 percent.

In some instances, the scores in the above Table 1-1 were calculated for a small number of cases (i.e., not all of the standards were applicable to every person in the study). Refer to Appendices A, B, and C for the number of eligible cases for each standard.

Findings Indicating Strong Case Management and/or Clinician Performance

A review of the highest scores across the GSAs for both adults and children indicates a theme of adherence to performance standards relating to case management and clinician involvement. Standards receiving the highest scores indicate:

- An assigned clinician is actively involved in the oversight of the treatment.
- Treatment plans incorporate the identified needs of the individual, include measurable goals that address those needs, and describe specific action steps to reasonably accomplish the goals.
- Case Management and the types and intensity of services are provided based on the needs identified in the individual's assessment and treatment recommendations.
- Services are provided in a timeframe responsive to the urgency of the individual's need.

Findings Indicating a Need for Improved Guidance and Protocols

A review of some of the lowest scores across the GSAs for both adults and children indicate a theme of a system-wide need for clearer protocols, policies, and procedures. Standards receiving some of the lowest scores involve process-related activities, including:

- Individuals'/families' cultural preferences are not being assessed and included in the development of treatment plans.
- Behavioral health care is not being coordinated with the PCP in all appropriate circumstances.
- Informed consent is not documented for individuals receiving prescribed medications.
- Regular assessments for movement disorders are not documented for individuals receiving anti-psychotic medication.

Findings Addressing Quality Clinical Outcomes

Outcomes were measured in the ICR by determining both symptomatic and functional improvement.

- Results were above the minimum performance scores for evidence of symptomatic and functional improvement for children.
- Although the target score of 80 percent was not met, results for the adults (SMI and non-SMI) were above 70 percent and close to meeting the minimum performance scores for evidence of symptomatic and functional improvement.

Conclusions and Recommendations

In the adult population, the statewide ICR results met or exceeded the minimum performance scores for 10 of the 20 performance standards. Within those 10 standards, the majority of the results were well above the expected minimum performance scores. These 10 standards generally encompass the areas of case management and clinical performance, indicating that on a statewide basis the GSAs have the infrastructure and processes in place in these two areas.

The child ICR results were strong overall, with performance meeting 15 of the 20 minimum performance scores. Additionally, the results for the child population were generally higher than those for the adult population on the same performance standards. Although a direct conclusion as to why the performance scores were higher for children than adults cannot be drawn within the scope of this study, some reasons behind these findings can be discussed. Possible conclusions may include a supposition that GSAs may generally focus more attention on children than adults, and/or overall performance on standards is improved when parents are actively engaged in the child's treatment planning process (Standard 3b).

Statewide the two lowest scores were for Standard 9, which addresses cultural competency and Standard 15, which addresses collaboration between the behavioral health provider and the PCP. For Standard 9, the ICR statewide adult score was 18.3 percent and the child score was 17.9 percent. These results should not be interpreted with surprise regarding Arizona's performance on this measure. A subcommittee from the President's New Freedom Commission on Mental Health addresses a need nationwide to increase cultural competency in the behavioral health setting, in light of the changing make-up of the population.[1] Census 2000 noted that Arizona had the second fastest population growth rate in the nation during the 1990s.[2] Due to this recent increase in migration, Arizona has become more aware of cultural diversity within the state population and its influence on the delivery of quality health care. By assessing cultural competency in the ICR, ADHS has already taken a great stride toward an increased awareness regarding the need to deliver behavioral health care in a culturally sensitive manner.

Standard 15 of the ICR measured the coordination of care between the behavioral health provider and the PCP. The ICR adult statewide score for Standard 15 was 52.4 percent and the child score was 56.2 percent. This finding fared better than a finding from a recent study reported by the Office of Health Policy and Clinical Outcomes, where less than 50 percent of the PCPs reported neither providing nor receiving information back from mental health providers.[3] This lack of collaboration nationwide can be attributed to a need of guidelines for the providers on successful collaboration, the sensitive nature of behavioral health information, and/or the continued problem of fragmentation between general medicine and specialty fields. This was echoed by a subcommittee from the President's New Freedom Commission on Mental Health, which points out the lack of coordination between behavioral health providers and general medicine, as well as a lack of guidelines to assist the providers in collaboration.[4]

In the area of establishing and measuring performance standards for behavioral health programs, Arizona is in the forefront. At the present time, two other western states are defining specific performance standards that are very similar to the ADHS standards. These states are Washington and Montana. *Performance Measures for Managing Washington State's Public Mental Health System* can be found at www.wa.gov/dshs/mentalhealth/pdf/mhdpireport.pdf. *Benchmarks, Goals & Objectives: Performance Goals for FY 2003 for Montana* can be found at www.dphhs.state.mt.us/about_us/goals_objectives/amd_goals_objectives.htm.

References

1 President's New Freedom Commission on Mental Health. Policy Options Subcommittee on Cultural Competence; February 6, 2003. Available at: www.mentalhealthcommission.gov. Accessed on June 21, 2003.

2 Kasindorf M, McMahon, P. Arizona's Hispanic population grew by 88%. *USA Today*. 2003. Available at: www.usatoday.com/news/nation/census/as.htm. Accessed on June 21, 2003.

3 Yuen E. Linkages between Primary Care Providers and Mental Health Specialists. Office of Health Policy and Clinical Outcomes. Available at: www.tju.edu/ohp/HPN/HPN.09.98/article4.cfm. Accessed on June 21, 2003.

4 President's New Freedom Commission on Mental Health. An Outline for the Draft Report of the Subcommittee on Mental Health Interface with General Medicine; January 8, 2003. Available at: www.mentalhealthcommission.gov. Accessed on June 21, 2003.

2. Introduction and Background

Introduction

The *ADHS Independent Case Review 2002* was requested by the Arizona Department of Health Services (ADHS) as an annual independent quality evaluation of care provided in the year 2002 to Title XIX and Title XXI enrolled individuals receiving behavioral health services.

Health Services Advisory Group, Inc. (HSAG) conducted the Independent Case Review (ICR) on a sample population of adults and children across the six Geographic Service Areas (GSAs). HSAG worked collaboratively with ADHS staff and area experts in the design of the chart audit tool, the scoring protocol, and the thresholds of acceptable compliance. HSAG coordinated with the GSAs in the procurement of medical records. HSAG then performed chart audits on the sample population.

This ICR report contains analysis of data from the chart audit at state and GSA levels for each of the identified standards in the audit tool.

Background

The behavioral health system administered by ADHS is a critical component of the overall health care system serving Arizona residents. ADHS contracts with Regional Behavioral Health Authorities (RBHAs) to deliver behavioral health services to six GSAs in the state:

- Community Partnership of Southern Arizona (CPSA-3), serving the four southeastern counties (Greenlee, Graham, Cochise, and Santa Cruz)
- Community Partnership of Southern Arizona (CPSA-5), serving Pima County
- The Excel Group, Inc. (EXCEL), serving Yuma and La Paz counties
- Northern Arizona Regional Behavioral Health Authority (NARBHA), serving Mohave, Coconino, Apache, Navajo, and Yavapai counties
- Pinal Gila Behavioral Health Association, Inc. (PGBHA), serving Pinal and Gila counties
- ValueOptions (VO), serving Maricopa County

ADHS also contracts with Tribal Regional Behavioral Health Authorities (TRBHA), including Pasqua Yaqui, Navajo, and Gila River.

The GSAs function similarly to a Health Maintenance Organization (HMO). They contract with a network of providers to deliver a full range of services, including prevention programs for children and adults and a full continuum of services for mental health and substance abuse disorders.

As part of an ongoing commitment to ensure that the GSAs provide quality behavioral health services that meet established guidelines and standards, ADHS, through its contract with the Arizona Health Care Cost Containment System (AHCCCS), is required to conduct an annual, independent review of the quality of care provided to Title XIX and Title XXI individuals.

The goal of the 2002 ICR is to establish a baseline measurement for clinical and practice outcomes. Aspects of performance which were reviewed included but were not limited to:

- Access to care
- Coordination of care with acute contractors/PCPs
- Sufficiency of assessments
- Individual and family involvement
- Cultural competency
- Informed consent
- Quality clinical outcomes

Sampling

A statistically reliable sample using a 90 percent confidence level, with a +/- 5 percent margin of error, was drawn from the statewide population of 57,303 Title XIX and Title XXI adults and children who met the following study criteria:

- Individuals were continuously enrolled in the Arizona behavioral health system for at least 90 days within the six months prior to implementation of the review (January 1, 2003).
- Individuals received a Title XIX- or Title XXI-funded service during the April 1, 2002 to December 31, 2002. (Individuals who received only transportation, laboratory, and/or radiology services were excluded from the study).

The sample cases were randomly selected at the GSA level, observing the adult/child enrollment ratio within each GSA. The Tribal Regional Behavioral Health Authorities (TRBHA) samples were likewise randomly selected from the eligible TRBHA population. The TRBHA sample size was determined as a subset of the GSA.

The final sample size consisted of 1,540 cases. Figure 3-1 shows the final sample sizes for each GSA. A 15-percent over-sample was created to allow for replacement of records in the original sample that were excluded from the study.

Figure 3-1—ADHS Independent Case Review 2002: Final Sample Sizes

	Final Sample Size		
GSA/RBHA	**Adult**	**Child**	**Total**
CPSA-3	161	88	249
CPSA-5	171	92	263
Excel	140	105	245
NARBHA	164	94	258
PGBHA	150	92	242
ValueOptions	170	100	270
TRBHA			
Navajo	1	1	2
Gila River	2	6	8
Pascua Yaqui	1	2	3
Total	**960**	**580**	**1,540**

Replacement Cases

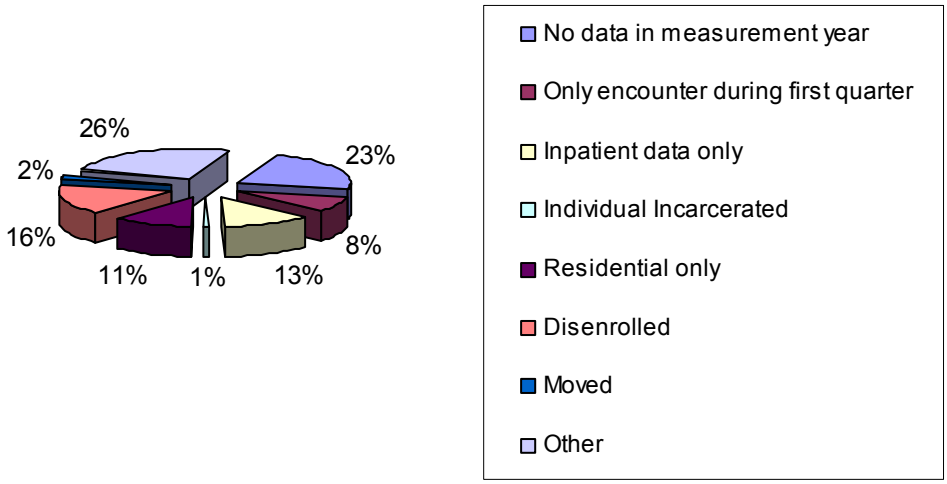
The abstraction tool was developed to capture community-based treatment. A sample case was replaced by another case from the over-sample if it was determined that (a) the individual's record contained only inpatient data, (b) the individual's record contained only residential treatment data, or (c) the individual was not enrolled during the entire measurement year.

Additional cases were referred to the Project Coordinator if, during the review period, the individual (a) was incarcerated, (b) moved, (c) was disenrolled, or (d) had a temporary inpatient or residential stay. The Project Coordinator then determined if a record was sufficiently complete for abstraction. HSAG replaced the sample case if the record was determined to be incomplete.

A total of 113 cases (or 7.3 percent) were replaced out of the original 1,540 sample cases. Figure 3-2 below displays the reasons individual cases were replaced.

Figure 3-2—ADHS Independent Case Review 2002: Reasons for Replacement

Reason for Replacement	Frequency	Percent
No data in measurement year	26	23.01%
Only encounter during first quarter	9	7.96%
Inpatient data only	15	13.27%
Individual Incarcerated	1	0.88%
Residential only	12	10.62%
Disenrolled	18	15.93%
Moved	2	1.77%
Other	30	26.55%



There were eight reasons for a sample case to be replaced, with the highest percentage of replacements due to "Other." The most common scenario for "Other" was "one time crisis services only." The second highest percentage of sample cases replaced was due to "No data in the measurement year." The smallest percentage replaced was due to incarceration.

Scoring of Data

The Independent Case Review (ICR) abstraction tool consisted of 21 standards. A minimum performance score has been established by ADHS for 20 of the 21 standards. The tool contained an additional two standards (i.e., Standards 22 and 23) used only for tracking purposes.

In order to measure each GSA's compliance against the minimum performance scores, a "Yes" answer was scored as one point, and a "No" answer was scored as zero points. For a given standard, the numerator was defined as the sum of all "Yes" answers, and the denominator is the sum of all "Yes" or "No" answers. The final score for each standard was calculated as the numerator divided by the denominator. TRBHA cases were not included in the calculation of the scores. Each final score was compared to the minimum performance score for each of the six GSAs.

Answers of "N/A" were excluded from both the numerator and denominator. For example, Standard 15e (Discharge from an Inpatient Setting) did not apply if the individual was not discharged from an inpatient setting during the review period. The denominator for standards with "skip patterns" was adjusted. For example, Standard 8 was dependent on answering "Yes" to Standard 7. If the answer to Standard 7 was "No" or "NA," then Standard 8 was "N/A" and not scored.

Standards 2 and 4 were scored individually and as a "roll-up" score, which was the sum of the numerators for Standards 2 and 4 divided by the sum of the denominators for Standards 2 and 4. Standards 16 and 17 were also scored in this manner. Similarly, all multiple-part standards (Standards 3, 5, 15, and 20) had both individual and roll-up scores.

HSAG created a final measure to determine overall performance scores. This overall performance score provides an indication of how often all required processes, services (e.g., case management), or outcomes were met. The statewide overall performance score is the sum of the positive numerators, or "Yes" answers, divided by the sum of the denominators, or "Yes" and "No" answers, across all standards, excluding Standard 13 (which has not established performance score). Similarly, HSAG ranked each GSA's overall performance using the above-mentioned scoring methodology. This was done separately for the adult and child samples, and the adult SMI and non-SMI sample cases by GSA.

For some standards, the exclusion of the "N/A" responses results in small sample sizes, and the results should be interpreted with caution. Sample sizes are reported on the graphs as an aid to the reader. Appendix C shows the distribution of "Yes," "No," and "N/A" responses obtained through abstraction of the behavioral health record for each ICR standard. The table displays the number and the percentage of each response.

4. Record Abstraction

A clinical chart audit tool based on the ADHS baseline for clinical and practice outcomes for 2002 was developed by ADHS in collaboration with HSAG and approved by AHCCCS. The draft chart audit tool was then edited into a concise and objective scannable chart audit tool, using HSAG's proven process to convert data elements into a data collection tool. The process considered the following factors:

- Reliability: Is the tool structured to solicit the necessary responses?
- Objectivity: Are the questions objective?
- Conciseness: Are extraneous data elements eliminated?
- Completeness: Are the study questions answered?

HSAG created a scannable chart audit tool using optical character recognition (OCR) software. Each tool was printed with a unique barcode identifying its respective sample case.

After each chart was abstracted onto an abstraction tool, the tool was scanned electronically to record the reviewer's responses. The tool itself was pre-tested for an accuracy tolerance of greater than 95 percent. A set of standard edits was run as a final validation step to review frequency distributions and valid range checks.

Eleven behavioral health professionals (psychiatric RNs, Certified Professional Counselors, Masters-level behavioral health professionals, MSWs, and PsyDs) were chosen from various fields and trained as reviewers to abstract behavioral health records efficiently, accurately, and reliably. Initially, HSAG conducted an extensive training session for these behavioral health professionals. Over the course of several days, these abstractors learned the background and purpose of the project, methodology used, abstraction tool and instructions, monitoring, and confidentiality policies. During the initial training session, abstractors reviewed a selected sample of behavioral health records, and results were calculated to determine Inter-Rater Reliability (IRR). Following the review, the HSAG Project Coordinator discussed the IRR results with the reviewers individually as well as in a group session format. The coordinator discussed each question with the reviewers to ensure that they had a clear understanding of the data collection instrument. All abstractors achieved a 95-percent reliability rate prior to field abstraction. Records from all GSAs were abstracted exclusively by these HSAG-trained reviewers.

HSAG utilized the Rater-To-Standard (RTS) method of monitoring the reliability and accuracy of the reviewers on an ongoing basis. The Project Coordinator randomly selected five percent of each abstractor's completed reviews for re-review. The Project Coordinator acted as the "gold standard" against which all other abstractors were evaluated. This process assured that reviewers were consistently abstracting the data in the same manner throughout the review process. Completed reviews were re-reviewed for any content errors, such as data omissions, incorrect data entry, and interpretation errors. Individual accuracy rates were tracked and early and ongoing feedback was provided to reviewers. Reviewers were required to maintain at least 95-percent reliability. If a reviewer fell below a 95-percent reliability rate, re-training was performed immediately and 100 percent review was performed until the reviewer returned to a 95-percent accuracy rate.

Presentation of Results

The results for the *ADHS 2002 Independent Case Review* are presented in sections 5 and 6. The results are based on the ICR standards and minimum performance scores listed in Table 5-1. Results are discussed by statewide strengths and then by statewide areas of concern.

A discussion by GSA is also presented based on the percentage of minimum performance scores. Results are then discussed based on strengths and areas of concern by GSA.

Each GSA is responsible for the oversight of case management, documentation processes, and following established policies and procedures. The ICR tool contains 20 minimum performance standards (excluding Standard 13) derived from 35 questions that address these areas of oversight. Based on all 35 questions, an overall performance score for each GSA is presented for both adults and children (see Figure 5-1 on page 5-27). The overall performance score for a GSA is the total number of positive or "Yes" answers for each individual in the GSA, divided by the total number of answers ("Yes" or "No") across all standards, excluding Standard 13.

In the GSA discussions, TRBHA individuals are not included in the calculation of the overall performance scores or the percentage of minimum performance scores met or exceeded.

Following the GSA discussions, results are presented in Section 6 by SMI and non-SMI. Appendix A contains a graph for each standard, detailing the percentage meeting each standard by GSA. Appendix B contains similar graphs by GSA for each standard based on the level of mental illness (i.e., SMI or non-SMI).

The discussions within each section address significant findings in the areas of strengths and concerns. Appendix C shows the distribution of responses by GSA. Appendix D shows the distribution of responses by TRBHA.

Table 5-1—ADHS Independent Case Review 2002: Results of ICR Standards 1-21 for Adults and Children				
#	ICR Standard	Minimum Performance Score	Statewide Results Adults	Children
1	Assessments are sufficiently comprehensive for the development of functional treatment recommendations.	85%	88.1%	85.3%
2	The types and intensity of services are provided based upon the needs identified in the individual's assessment and treatment recommendations.	85%	90.7%	91.6%
3	Staff actively engage the following in the treatment planning process:	85%	83.6%	88.3%
	a. individual		96.0%	84.4%
	b. family		48.3%	93.3%
	c. other agencies		87.7%	86.8%
4	Case management services are provided based on the individual's assessment and treatment recommendations.	85%	93.0%	96.0%
5	Outreach/follow-up occurs after:	80%	77.3%	73.2%
	a. discharge from inpatient		94.3%	78.3%
	b. discharge from residential		78.1%	83.3%
	c. missed appointments		72.8%	70.2%
	d. crisis episodes		89.6%	89.2%
	e. service refusal		64.2%	73.6%
	f. medication refusal		82.4%	80.0%
6	FOR DDD MEMBERS ONLY: Individuals with identified specialized service needs are referred for and receive these services.	85%	82.1%	98.0%
7	The individual has an assigned clinician.	80%	97.2%	98.1%
8	The assigned clinician is actively involved in the oversight of the treatment.	80%	96.5%	98.0%
9	Individuals'/families' cultural preferences are assessed and included in the development of treatment plans.	70%	18.3%	17.9%
10	Individuals and/or parent/guardians are informed about and give consent for prescribed medications.	80%	53.2%	53.6%
11	If the individual has been prescribed anti-psychotic medication, regular assessments for movement disorders are documented.	70%	58.4%	62.1%
12	If the individual has been prescribed psychotropic medication and adverse reactions or side effects are noted, progress notes include documentation of follow-up actions to address adverse effects.	85%	82.1%	89.5%
13	If the individual has been prescribed psychotropic medication, the record includes documentation of specific target symptoms.	No Minimum Performance Score	63.2%	67.8%
14	The disposition of the referral from the PCP or Health Plan is communicated to the PCP or Health Plan within 30 days of receiving the request for service.	60%	69.0%	78.6%

Table 5-1—ADHS Independent Case Review 2002: Results of ICR Standards 1-21 for Adults and Children				
#	ICR Standard	Minimum Performance Score	Statewide Results Adults	Children
15	Behavioral health care has been communicated or attempts have been made to coordinate with the PCP in the following circumstances:	60%	52.4%	56.2%
	a. initial assessment and treatment recommendations		63.1%	67.6%
	b. initiation and significant changes in psychotropic medications and significant adverse reactions		55.4%	51.4%
	c. results of relevant laboratory, radiology and other tests		50.9%	51.1%
	d. emergency/crisis admission or events		31.1%	12.5%
	e. discharge from an inpatient setting		27.0%	25.0%
	f. disenrollment from ADHS/RBHA		17.7%	28.2%
	g. any other events requiring medical consultation with the individual's PCP		67.5%	76.2%
16	There is evidence of symptomatic improvement.	80%	74.4%	83.5%
17	There is evidence of functional improvement.	80%	72.2%	82.2%
18	Service plans and/or services are revised based on progress or lack of progress in the individual's behavioral health condition.	70%	75.0%	81.4%
19	Service plans and/or services are revised based on significant changes in the individual's behavioral health condition.	70%	72.5%	77.8%
20	The treatment plan:	80%	95.7%	95.7%
	a. incorporates the identified needs of the individual		95.7%	96.2%
	b. includes measurable goals which address those needs		95.1%	95.3%
	c. describes specific action steps to reasonably accomplish the goals		96.4%	95.5%
21	Services are provided in a timeframe responsive to the urgency of the member's need.	85%	94.5%	95.8%

Refer to Appendix A for sample sizes and Appendix C for the distribution of responses.

Statewide Strengths

Adults and Children

Statewide the minimum performance scores for Standards 1, 2, 4, 7, 8, 14, 18, 19, 20, and 21 for both the adult and child populations were met or exceeded. This indicates that across all service areas the standards below are being met or exceeded.

These data suggest the GSAs are consistently performing well in the areas of case management, clinician involvement/oversight and the provision of appropriate types and intensity of services.

#	ICR Standard	Minimum Performance Score	Statewide Results Adults	Children
1	Assessments are sufficiently comprehensive for the development of functional treatment recommendations.	85%	88.1%	85.3%
2	The types and intensity of services are provided based upon the needs identified in the individual's assessment and treatment recommendations.	85%	90.7%	91.6%
4	Case management services are provided based on the individual's assessment and treatment recommendations.	85%	93.0%	96.0%
7	The individual has an assigned clinician.	80%	97.2%	98.1 %
8	The assigned clinician is actively involved in the oversight of the treatment.	80%	96.5%	98.0%
14	The disposition of the referral from the PCP or Health Plan is communicated to the PCP or Health Plan within 30 days of receiving the request for service.	60%	69.0%	78.6%
18	Service plans and/or services are revised based on progress or lack of progress in the individual's behavioral health condition.	70%	75.0%	81.4%
19	Service plans and/or services are revised based on significant changes in the individual's behavioral health condition.	70%	72.5%	77.8%
20	The treatment plan incorporates the identified needs of the individual, includes measurable goals which address those needs, and describes specific action steps to reasonably accomplish the goals.	80%	95.7%	95.7%
21	Services are provided in a timeframe responsive to the urgency of the member's need.	85%	94.5%	95.8%

Adults

Statewide, 10 of the 20 minimum performance scores were met or exceeded for adults (50.0 percent). Standards 1, 2, 4, 7, 8, 14, 18, 19, 20, and 21 met or exceeded the minimum performance scores.

#	ICR Standard	Minimum Performance Score	Statewide Results Adults
1	Assessments are sufficiently comprehensive for the development of functional treatment recommendations.	85%	88.1%
2	The types and intensity of services are provided based upon the needs identified in the individual's assessment and treatment recommendations.	85%	90.7%
4	Case management services are provided based on the individual's assessment and treatment recommendations.	85%	93.0%
7	The individual has an assigned clinician.	80%	97.2%
8	The assigned clinician is actively involved in the oversight of the treatment.	80%	96.5%
14	The disposition of the referral from the PCP or Health Plan is communicated to the PCP or Health Plan within 30 days of receiving the request for service.	60%	69.0%
18	Service plans and/or services are revised based on progress or lack of progress in the individual's behavioral health condition.	70%	75.0%
19	Service plans and/or services are revised based on significant changes in the individual's behavioral health condition.	70%	72.5%
20	The treatment plan incorporates the identified needs of the individual, includes measurable goals which address those needs, and describes specific action steps to reasonably accomplish the goals.	80%	95.7%
21	Services are provided in a timeframe responsive to the urgency of the member's need.	85%	94.5%

Children

Statewide, 15 of the 20 minimum performance scores were met or exceeded for children (75.0 percent). Standards 1, 2, 3, 4, 6, 7, 8, 12,14, 16, 17, 18, 19, 20, and 21 met or exceeded the minimum performance scores.

Standards 16 and 17 address outcomes, and it should be noted that statewide outcomes for children exceeded the minimum performance scores.

For child DDD individuals, the minimum performance score for Standard 6 was exceeded at 98.0 percent.

#	ICR Standard	Minimum Performance Score	Statewide Results Children
1	Assessments are sufficiently comprehensive for the development of functional treatment recommendations.	85%	85.3%
2	The types and intensity of services are provided based upon the needs identified in the individual's assessment and treatment recommendations.	85%	91.6%
3	Staff actively engage the following in the treatment planning process: individual, family, and other agencies.	85%	88.3%
4	Case management services are provided based on the individual's assessment and treatment recommendations.	85%	96.0%
6	FOR DDD MEMBERS ONLY: Individuals with identified specialized service needs are referred for and receive these services.	85%	98.0%
7	The individual has an assigned clinician.	80%	98.1%
8	The assigned clinician is actively involved in the oversight of the treatment.	80%	98.0%
12	If the individual has been prescribed psychotropic medication and adverse reactions or side effects are noted, progress notes include documentation of follow-up actions to address adverse effects.	85%	89.5%
14	The disposition of the referral from the PCP or Health Plan is communicated to the PCP or Health Plan within 30 days of receiving the request for service.	60%	78.6%
16	There is evidence of symptomatic improvement.	80%	83.5%
17	There is evidence of functional improvement.	80%	82.2%
18	Service plans and/or services are revised based on progress or lack of progress in the individual's behavioral health condition.	70%	81.4%
19	Service plans and/or services are revised based on significant changes in the individual's behavioral health condition.	70%	77.8%
20	The treatment plan incorporates the identified needs of the individual, includes measurable goals which address those needs, and describes specific action steps to reasonably accomplish the goals.	80%	95.7%
21	Services are provided in a timeframe responsive to the urgency of the member's need.	85%	95.8%

Statewide Concerns

Adults and Children

Standard 5 addresses outreach/follow-up activities. The statewide score was 77.3 percent for adults and 73.2 percent for children, not meeting the minimum performance score of 80 percent. Statewide the minimum performance scores for Standards 9 and 10 for either the adult or child populations were not met. The statewide score for Standard 9 was 18.3 percent for adults and 17.9 percent for children. The statewide score for Standard 10 was 53.2 percent for adults and 53.6 percent for children. This indicates that across all service areas the following standards were not being met or exceeded:

#	ICR Standard	Minimum Performance Score	Statewide Results Adults	Children
5	Outreach/follow-up occurs after discharge from inpatient and from residential, missed appointments, crisis episodes, service refusal, and medication refusal.	80%	77.3%	73.2%
9	Individuals'/families' cultural preferences are assessed and included in the development of treatment plans.	70%	18.3%	17.9%
10	Individuals and/or parent/guardians are informed about and give consent for prescribed medications.	80%	53.2%	53.6%

The statewide results also fell below the minimum performance score for both adults (58.4 percent) and children (62.1 percent) for Standard 11.

In addition, only one GSA met the minimum performance score for Standard 15, with a statewide result of 52.4 percent for adults and 56.2 percent for children.

#	ICR Standard	Minimum Performance Score	Statewide Results Adults	Children
11	If the individual has been prescribed anti-psychotic medication, regular assessments for movement disorders are documented.	70%	58.4%	62.1%
15	Behavioral health care has been communicated or attempts have been made to coordinate with the PCP in the following circumstances: initial assessment and treatment recommendations; initiation and significant changes in psychotropic medications and significant adverse reactions; results of relevant laboratory, radiology and other tests; emergency/crisis admission or events; discharge from an inpatient setting; disenrollment from ADHS/RBHA; and any other events requiring medical consultation with the individual's PCP.	60%	52.4%	56.2%

Adults

As presented on the previous page, the statewide results for Standards 5, 9, 10, 11, and 15 fell below the minimum performance scores for both adults and children. Additionally, at 82.1 percent, the adult DDD population addressed in Standard 6 also fell below the 85 percent minimum performance score. Standards 16 and 17 address symptomatic and functional outcomes. For the adult population, the statewide scores of 74.4 percent for Standard 16 and 72.2 percent for Standard 17 were below the 80 percent minimum performance score.

#	ICR Standard	Minimum Performance Score	Statewide Results Adults
5	Outreach/follow-up occurs after discharge from inpatient and from residential, missed appointments, crisis episodes, service refusal, and medication refusal.	80%	77.3%
6	FOR DDD MEMBERS ONLY: Individuals with identified specialized service needs are referred for and receive these services.	85%	82.1%
9	Individuals'/families' cultural preferences are assessed and included in the development of treatment plans.	70%	18.3%
10	Individuals and/or parent/guardians are informed about and give consent for prescribed medications.	80%	53.2%
11	If the individual has been prescribed anti-psychotic medication, regular assessments for movement disorders are documented.	70%	58.4%
15	Behavioral health care has been communicated or attempts have been made to coordinate with the PCP in the following circumstances: initial assessment and treatment recommendations; initiation and significant changes in psychotropic medications and significant adverse reactions; results of relevant laboratory, radiology and other tests; emergency/crisis admission or events; discharge from an inpatient setting; disenrollment from ADHS/RBHA; and any other events requiring medical consultation with the individual's PCP.	60%	52.4%
16	There is evidence of symptomatic improvement.	80%	74.4%
17	There is evidence of functional improvement.	80%	72.2%

Children

The statewide results for Standards 5, 9, 10, 11, and 15 were below the minimum performance scores for children as well as adults. There were no additional concerns directed only at the child population.

#	ICR Standard	Minimum Performance Score	Statewide Results Children
5	Outreach/follow-up occurs after discharge from inpatient and from residential, missed appointments, crisis episodes, service refusal, and medication refusal.	80%	73.2%
9	Individuals'/families' cultural preferences are assessed and included in the development of treatment plans.	70%	17.9%
10	Individuals and/or parent/guardians are informed about and give consent for prescribed medications.	80%	53.6%
11	If the individual has been prescribed anti-psychotic medication, regular assessments for movement disorders are documented.	70%	62.1%
15	Behavioral health care has been communicated or attempts have been made to coordinate with the PCP in the following circumstances: initial assessment and treatment recommendations; initiation and significant changes in psychotropic medications and significant adverse reactions; results of relevant laboratory, radiology and other tests; emergency/crisis admission or events; discharge from an inpatient setting; disenrollment from ADHS/RBHA; and any other events requiring medical consultation with the individual's PCP.	60%	56.2%

Strengths and Areas of Concern by Geographic Service Area

Appendix A contains graphs showing the results by standard and by GSA for adults and children. The following paragraphs address the information in Appendix A.

CPSA-3

Strengths: CPSA-3 scored high in the areas addressing treatment planning, case management and types and intensity of services and assessments, scoring the highest of the GSAs at 94.4 percent for adults and 93.2 percent for children on Standard 1, which addresses sufficiently comprehensive assessments.

For Adults:

CPSA-3 met or exceeded the following minimum performance scores:

#	ICR Standard	Minimum Performance Score	CPSA-3 Results Adults
1	Assessments are sufficiently comprehensive for the development of functional treatment recommendations.	85%	94.4%
2	The types and intensity of services are provided based upon the needs identified in the individual's assessment and treatment recommendations.	85%	93.2%
3	Staff actively engage the following in the treatment planning process: individual, family, and other agencies.	85%	85.2%
4	Case management services are provided based on the individual's assessment and treatment recommendations.	85%	94.4%
7	The individual has an assigned clinician.	80%	99.4%
8	The assigned clinician is actively involved in the oversight of the treatment.	80%	94.4%
14	The disposition of the referral from the PCP or Health Plan is communicated to the PCP or Health Plan within 30 days of receiving the request for service.	60%	71.4%
18	Service plans and/or services are revised based on progress or lack of progress in the individual's behavioral health condition.	70%	81.3%
20	The treatment plan incorporates the identified needs of the individual, includes measurable goals which address those needs, and describes specific action steps to reasonably accomplish the goals.	80%	96.0%
21	Services are provided in a timeframe responsive to the urgency of the member's need.	85%	93.2%

For Children:

CPSA-3 met or exceeded the following minimum performance scores:

#	ICR Standard	Minimum Performance Score	CPSA-3 Results Children
1	Assessments are sufficiently comprehensive for the development of functional treatment recommendations.	85%	93.2%
2	The types and intensity of services are provided based upon the needs identified in the individual's assessment and treatment recommendations.	85%	95.5%
3	Staff actively engage the following in the treatment planning process: individual, family, and other agencies.	85%	92.1%
4	Case management services are provided based on the individual's assessment and treatment recommendations.	85%	98.9%
7	The individual has an assigned clinician.	80%	100%
8	The assigned clinician is actively involved in the oversight of the treatment.	80%	100%
14	The disposition of the referral from the PCP or Health Plan is communicated to the PCP or Health Plan within 30 days of receiving the request for service.	60%	85.7%
16	There is evidence of symptomatic improvement.	80%	81.7%
17	There is evidence of functional improvement.	80%	82.9%
18	Service plans and/or services are revised based on progress or lack of progress in the individual's behavioral health condition.	70%	89.3%
19	Service plans and/or services are revised based on significant changes in the individual's behavioral health condition.	70%	88.0%
20	The treatment plan incorporates the identified needs of the individual, includes measurable goals which address those needs, and describes specific action steps to reasonably accomplish the goals.	80%	96.0%
21	Services are provided in a timeframe responsive to the urgency of the member's need.	85%	94.3%

Areas of Concern: CPSA-3 fell below the minimum performance score for Standards 5, 6, 9, 10, 11, 12 and 15 for both adults and children.

The results for Standard 9, which addresses the assessment and inclusion in the treatment plan of individual/family cultural preferences, was 5.0 percent for adults and 4.5 percent for children. The results for Standard 15, which considers coordination of PCPs and mental health providers, were also below the minimum performance scores (52.6 percent and 55.4 percent for adults and children, respectively).

CPSA-3 did not meet the minimum performance scores for any standard addressing medications (i.e., Standards 10, 11 and 12).

#	ICR Standard	Minimum Performance Score	CPSA-3 Results Adults	Children
5	Outreach/follow-up occurs after discharge from inpatient and from residential, missed appointments, crisis episodes, service refusal, and medication refusal.	80%	68.3%	68.8%
6	FOR DDD MEMBERS ONLY: Individuals with identified specialized service needs are referred for and receive these services.	85%	75.0%	80.0%
9	Individuals'/families' cultural preferences are assessed and included in the development of treatment plans.	70%	5.0%	4.5%
10	Individuals and/or parent/guardians are informed about and give consent for prescribed medications.	80%	37.3%	38.9%
11	If the individual has been prescribed anti-psychotic medication, regular assessments for movement disorders are documented.	70%	58.5%	55.6%
12	If the individual has been prescribed psychotropic medication and adverse reactions or side effects are noted, progress notes include documentation of follow-up actions to address adverse effects.	85%	82.1%	81.8%
15	Behavioral health care has been communicated or attempts have been made to coordinate with the PCP in the following circumstances: initial assessment and treatment recommendations; initiation and significant changes in psychotropic medications and significant adverse reactions; results of relevant laboratory, radiology and other tests; emergency/crisis admission or events; discharge from an inpatient setting; disenrollment from ADHS/RBHA; and any other events requiring medical consultation with the individual's PCP.	60%	52.6%	55.4%

CPSA-5

Strengths: CPSA-5 did well on Standards 2 and 4, addressing case management and types and intensity of services, as well as Standard 3, which addresses engagement of the individual, family and other agencies in the treatment planning process. CPSA-5 scored high on Standard 21, at 97.7 percent for adults and 95.7 percent for children, which indicates services are provided in a timeframe responsive to the urgency of the individual's need.

For Adults:

CPSA-5 met or exceeded the following minimum performance scores:

#	ICR Standard	Minimum Performance Score	CPSA-5 Results Adults
2	The types and intensity of services are provided based upon the needs identified in the individual's assessment and treatment recommendations.	85%	93.0%
3	Staff actively engage the following in the treatment planning process: individual, family, and other agencies.	85%	89.7%
4	Case management services are provided based on the individual's assessment and treatment recommendations.	85%	94.7%
5	Outreach/follow-up occurs after discharge from inpatient and from residential, missed appointments, crisis episodes, service refusal, and medication refusal.	80%	83.3%
6	FOR DDD MEMBERS ONLY: Individuals with identified specialized service needs are referred for and receive these services.	85%	100%
7	The individual has an assigned clinician.	80%	98.2%
8	The assigned clinician is actively involved in the oversight of the treatment.	80%	97.6%
14	The disposition of the referral from the PCP or Health Plan is communicated to the PCP or Health Plan within 30 days of receiving the request for service.	60%	77.8%
18	Service plans and/or services are revised based on progress or lack of progress in the individual's behavioral health condition.	70%	76.7%
20	The treatment plan incorporates the identified needs of the individual, includes measurable goals which address those needs, and describes specific action steps to reasonably accomplish the goals.	80%	96.6%
21	Services are provided in a timeframe responsive to the urgency of the member's need.	85%	97.7%

For Children:

CPSA-5 met or exceeded the following minimum performance scores:

#	ICR Standard	Minimum Performance Score	CPSA-5 Results Children
2	The types and intensity of services are provided based upon the needs identified in the individual's assessment and treatment recommendations.	85%	88.0%
3	Staff actively engage the following in the treatment planning process: individual, family, and other agencies.	85%	85.6%
4	Case management services are provided based on the individual's assessment and treatment recommendations.	85%	95.7%
6	FOR DDD MEMBERS ONLY: Individuals with identified specialized service needs are referred for and receive these services.	85%	100%
7	The individual has an assigned clinician.	80%	98.9%
8	The assigned clinician is actively involved in the oversight of the treatment.	80%	97.8%
12	If the individual has been prescribed psychotropic medication and adverse reactions or side effects are noted, progress notes include documentation of follow-up actions to address adverse effects.	85%	93.8%
14	The disposition of the referral from the PCP or Health Plan is communicated to the PCP or Health Plan within 30 days of receiving the request for service.	60%	100%
18	Service plans and/or services are revised based on progress or lack of progress in the individual's behavioral health condition.	70%	81.7%
20	The treatment plan incorporates the identified needs of the individual, includes measurable goals which address those needs, and describes specific action steps to reasonably accomplish the goals.	80%	96.6%
21	Services are provided in a timeframe responsive to the urgency of the member's need.	85%	95.7%

Areas of Concern: The results for CPSA-5 were below the minimum performance score for Standards 1, 9, 10, 11, 15, 16, 17 and 19 for both adults and children.

The results for Standard 9, which addresses the assessment and inclusion in the treatment plan of individual/family cultural preferences, was 11.1 percent for adults and 13.0 percent for children. The results for Standard 15, which considers coordination of PCPs and mental health providers, were 54.3 percent and 51.3 percent for adults and children, respectively.

For adults, CPSA-5 did not meet the minimum performance scores for any standard addressing medications (i.e., Standards 10, 11, and 12), while only Standard 12 was met for children.

Standard 1 addresses comprehensive assessment, Standards 16 and 17 address outcomes and improvement, and Standard 19 considers revisions to services and/or service plans based on changes in the individual's behavioral health condition. Improvement in comprehensive assessment (Standard 1) may lead to higher results in Standards 10, 11, and 19, and improved outcomes (Standards 16 and 17).

#	ICR Standard	Minimum Performance Score	CPSA-5 Results Adults	Children
1	Assessments are sufficiently comprehensive for the development of functional treatment recommendations.	85%	84.2%	70.7%
9	Individuals'/families' cultural preferences are assessed and included in the development of treatment plans.	70%	11.1%	13.0%
10	Individuals and/or parent/guardians are informed about and give consent for prescribed medications.	80%	33.0%	54.0%
11	If the individual has been prescribed anti-psychotic medication, regular assessments for movement disorders are documented.	70%	40.5%	21.4%
15	Behavioral health care has been communicated or attempts have been made to coordinate with the PCP in the following circumstances: initial assessment and treatment recommendations; initiation and significant changes in psychotropic medications and significant adverse reactions; results of relevant laboratory, radiology and other tests; emergency/crisis admission or events; discharge from an inpatient setting; disenrollment from ADHS/RBHA; and any other events requiring medical consultation with the individual's PCP.	60%	54.3%	51.3%
16	There is evidence of symptomatic improvement.	80%	72.4%	78.3%
17	There is evidence of functional improvement.	80%	71.8%	76.2%
19	Service plans and/or services are revised based on significant changes in the individual's behavioral health condition.	70%	63.6%	63.6%

EXCEL

Strengths: EXCEL scored higher than the other GSAs on Standard 15, which is a roll-up score addressing the coordination of behavioral health care with the primary care physician. EXCEL exceeded the minimum performance score for Standard 15 (set at 60 percent) with 75.0 percent for adults and 78.4 percent for children. No other GSA met this minimum performance score. EXCEL was also the only GSA to exceed the minimum performance score for both adults and children for the combined Standards 16 and 17, addressing outcomes. Although EXCEL fell below the minimum performance score for Standard 9, the scores of 30.0 percent for adults and 28.6 percent for children were the highest among the GSAs at addressing cultural preferences.

For Adults:

EXCEL met or exceeded the following minimum performance scores:

#	ICR Standard	Minimum Performance Score	EXCEL Results Adults
2	The types and intensity of services are provided based upon the needs identified in the individual's assessment and treatment recommendations.	85%	85.0%
3	Staff actively engage the following in the treatment planning process: individual, family, and other agencies.	85%	85.6%
4	Case management services are provided based on the individual's assessment and treatment recommendations.	85%	87.9%
6	FOR DDD MEMBERS ONLY: Individuals with identified specialized service needs are referred for and receive these services.	85%	100%
7	The individual has an assigned clinician.	80%	95.0%
8	The assigned clinician is actively involved in the oversight of the treatment.	80%	92.4%
12	If the individual has been prescribed psychotropic medication and adverse reactions or side effects are noted, progress notes include documentation of follow-up actions to address adverse effects.	85%	85.2%
14	The disposition of the referral from the PCP or Health Plan is communicated to the PCP or Health Plan within 30 days of receiving the request for service.	60%	82.4%
15	Behavioral health care has been communicated or attempts have been made to coordinate with the PCP in the following circumstances: initial assessment and treatment recommendations; initiation and significant changes in psychotropic medications and significant adverse reactions; results of relevant laboratory, radiology and other tests; emergency/crisis admission or events; discharge from an inpatient setting; disenrollment from ADHS/RBHA; and any other events requiring medical consultation with the individual's PCP.	60%	75.0%
16	There is evidence of symptomatic improvement.	80%	82.5%
17	There is evidence of functional improvement.	80%	80.8%
19	Service plans and/or services are revised based on significant changes in the individual's behavioral health condition.	70%	87.5%

#	ICR Standard	Minimum Performance Score	EXCEL Results Adults
20	The treatment plan incorporates the identified needs of the individual, includes measurable goals which address those needs, and describes specific action steps to reasonably accomplish the goals.	80%	96.2%
21	Services are provided in a timeframe responsive to the urgency of the member's need.	85%	90.0%

For Children:

EXCEL met or exceeded the following minimum performance scores:

#	ICR Standard	Minimum Performance Score	EXCEL Results Children
1	Assessments are sufficiently comprehensive for the development of functional treatment recommendations.	85%	85.7%
2	The types and intensity of services are provided based upon the needs identified in the individual's assessment and treatment recommendations.	85%	87.6%
4	Case management services are provided based on the individual's assessment and treatment recommendations.	85%	92.4%
6	FOR DDD MEMBERS ONLY: Individuals with identified specialized service needs are referred for and receive these services.	85%	100%
7	The individual has an assigned clinician.	80%	97.1%
8	The assigned clinician is actively involved in the oversight of the treatment.	80%	95.0%
12	If the individual has been prescribed psychotropic medication and adverse reactions or side effects are noted, progress notes include documentation of follow-up actions to address adverse effects.	85%	90.0%
14	The disposition of the referral from the PCP or Health Plan is communicated to the PCP or Health Plan within 30 days of receiving the request for service.	60%	80.0%
15	Behavioral health care has been communicated or attempts have been made to coordinate with the PCP in the following circumstances: initial assessment and treatment recommendations; initiation and significant changes in psychotropic medications and significant adverse reactions; results of relevant laboratory, radiology and other tests; emergency/crisis admission or events; discharge from an inpatient setting; disenrollment from ADHS/RBHA; and any other events requiring medical consultation with the individual's PCP.	60%	78.4%
16	There is evidence of symptomatic improvement.	80%	83.1%
17	There is evidence of functional improvement.	80%	84.9%
18	Service plans and/or services are revised based on progress or lack of progress in the individual's behavioral health condition.	70%	73.3%
19	Service plans and/or services are revised based on significant changes in the individual's behavioral health condition.	70%	83.3%

#	ICR Standard	Minimum Performance Score	EXCEL Results Children
20	The treatment plan incorporates the identified needs of the individual, includes measurable goals which address those needs, and describes specific action steps to reasonably accomplish the goals.	80%	92.7%
21	Services are provided in a timeframe responsive to the urgency of the member's need.	85%	93.3%

Areas of Concern: EXCEL fell below the minimum performance scores for both adults and children for Standard 5, which addresses outreach and follow-up. The results for Standard 9, which addresses the assessment and inclusion in the treatment plan of individual/family cultural preferences, was 30.0 percent for adults and 28.6 percent for children. EXCEL also fell below the minimum performance scores on Standards 10 and 11, addressing medications.

#	ICR Standard	Minimum Performance Score	EXCEL Results Adults	EXCEL Results Children
5	Outreach/follow-up occurs after discharge from inpatient and from residential, missed appointments, crisis episodes, service refusal, and medication refusal.	80%	67.7%	67.5%
9	Individuals'/families' cultural preferences are assessed and included in the development of treatment plans.	70%	30.0%	28.6%
10	Individuals and/or parent/guardians are informed about and give consent for prescribed medications.	80%	47.0%	30.4%
11	If the individual has been prescribed anti-psychotic medication, regular assessments for movement disorders are documented.	70%	50.0%	62.5%

NARBHA

Strengths: NARBHA scored consistently, meeting or exceeding minimum performance scores 75.0 percent of the time for both children and adults. NARBHA was strong in clinician involvement and oversight, treatment planning, and providing case management and appropriate types and intensity of services.

For Adults:

NARBHA met or exceeded the following minimum performance scores:

#	ICR Standard	Minimum Performance Score	NARBHA Results Adults
1	Assessments are sufficiently comprehensive for the development of functional treatment recommendations.	85%	85.4%
2	The types and intensity of services are provided based upon the needs identified in the individual's assessment and treatment recommendations.	85%	93.3%
3	Staff actively engage the following in the treatment planning process: individual, family, and other agencies.	85%	88.9%
4	Case management services are provided based on the individual's assessment and treatment recommendations.	85%	96.3%
5	Outreach/follow-up occurs after discharge from inpatient and from residential, missed appointments, crisis episodes, service refusal, and medication refusal.	80%	87.9%
6	FOR DDD MEMBERS ONLY: Individuals with identified specialized service needs are referred for and receive these services.	85%	85.7%
7	The individual has an assigned clinician.	80%	100%
8	The assigned clinician is actively involved in the oversight of the treatment.	80%	98.8%
12	If the individual has been prescribed psychotropic medication and adverse reactions or side effects are noted, progress notes include documentation of follow-up actions to address adverse effects.	85%	91.5%
14	The disposition of the referral from the PCP or Health Plan is communicated to the PCP or Health Plan within 30 days of receiving the request for service.	60%	83.3%
16	There is evidence of symptomatic improvement.	80%	84.4%
17	There is evidence of functional improvement.	80%	82.4%
18	Service plans and/or services are revised based on progress or lack of progress in the individual's behavioral health condition.	70%	76.5%
19	Service plans and/or services are revised based on significant changes in the individual's behavioral health condition.	70%	75.4%
20	The treatment plan incorporates the identified needs of the individual, includes measurable goals which address those needs, and describes specific action steps to reasonably accomplish the goals.	80%	96.8%
21	Services are provided in a timeframe responsive to the urgency of the member's need.	85%	97.6%

For Children:

NARBHA met or exceeded the following minimum performance scores:

#	ICR Standard	Minimum Performance Score	NARBHA Results Children
1	Assessments are sufficiently comprehensive for the development of functional treatment recommendations.	85%	85.1%
2	The types and intensity of services are provided based upon the needs identified in the individual's assessment and treatment recommendations.	85%	92.6%
3	Staff actively engage the following in the treatment planning process: individual, family, and other agencies.	85%	92.5%
4	Case management services are provided based on the individual's assessment and treatment recommendations.	85%	95.7%
6	FOR DDD MEMBERS ONLY: Individuals with identified specialized service needs are referred for and receive these services.	85%	100%
7	The individual has an assigned clinician.	80%	97.9%
8	The assigned clinician is actively involved in the oversight of the treatment.	80%	97.8%
11	If the individual has been prescribed anti-psychotic medication, regular assessments for movement disorders are documented.	70%	81.3%
12	If the individual has been prescribed psychotropic medication and adverse reactions or side effects are noted, progress notes include documentation of follow-up actions to address adverse effects.	85%	92.3%
14	The disposition of the referral from the PCP or Health Plan is communicated to the PCP or Health Plan within 30 days of receiving the request for service.	60%	100%
16	There is evidence of symptomatic improvement.	80%	80.2%
18	Service plans and/or services are revised based on progress or lack of progress in the individual's behavioral health condition.	70%	77.9%
19	Service plans and/or services are revised based on significant changes in the individual's behavioral health condition.	70%	70.0%
20	The treatment plan incorporates the identified needs of the individual, includes measurable goals which address those needs, and describes specific action steps to reasonably accomplish the goals.	80%	95.0%
21	Services are provided in a timeframe responsive to the urgency of the member's need.	85%	96.8%

Areas of Concern: Performance on Standard 9, addressing cultural preferences, was 27.4 percent for adults and 18.1 percent for children. NARBHA had a low score when compared to the other GSAs on Standard 15, which is a roll-up score addressing the coordination of behavioral health care with the primary care physician. NARBHA scored 42.3 percent for adults and 48.2 percent for children. Although NARBHA came close to meeting the minimum performance score on the combined Standards 16 and 17 for children at 78.5 percent, NARBHA was the only GSA to show poorer outcomes for children than adults in this area.

#	ICR Standard	Minimum Performance Score	NARBHA Results Adults	Children
9	Individuals'/families' cultural preferences are assessed and included in the development of treatment plans.	70%	27.4%	18.1%
10	Individuals and/or parent/guardians are informed about and give consent for prescribed medications.	80%	53.7%	73.5%
15	Behavioral health care has been communicated or attempts have been made to coordinate with the PCP in the following circumstances: initial assessment and treatment recommendations; initiation and significant changes in psychotropic medications and significant adverse reactions; results of relevant laboratory, radiology and other tests; emergency/crisis admission or events; discharge from an inpatient setting; disenrollment from ADHS/RBHA; and any other events requiring medical consultation with the individual's PCP.	60%	42.3%	48.2%
16–17 Combined	There is evidence of symptomatic and functional improvement.	80%	83.4%*	78.5%
17	There is evidence of functional improvement.	80%	82.4%*	76.7%

*Although these results exceed the minimum performance score, they are provided for comparison purposes.

PGBHA

Strengths: PGBHA leads the GSAs on Standards 2 and 4 for adults. These standards focus on the appropriateness of case management and the types and intensity of services. PGBHA also did very well on Standards 7 and 8, addressing clinician oversight. Although not meeting the minimum performance score for Standard 10, which addresses informed consent for medications, PGBHA scored the highest of the GSAs at 73.6 percent for adults and 64.7 percent for children. PGBHA did well on treatment planning and also scored the highest of the GSAs on Standard 18 for both adults and children and on Standard 19 for adults. Standards 18 and 19 address revision of service plans and/or services based on changes or progress in the individual's behavioral health condition.

For Adults:

PGBHA met or exceeded the following minimum performance scores:

#	ICR Standard	Minimum Performance Score	PGBHA Results Adults
1	Assessments are sufficiently comprehensive for the development of functional treatment recommendations.	85%	90.7%
2	The types and intensity of services are provided based upon the needs identified in the individual's assessment and treatment recommendations.	85%	96.0%
4	Case management services are provided based on the individual's assessment and treatment recommendations.	85%	99.3%
5	Outreach/follow-up occurs after discharge from inpatient and from residential, missed appointments, crisis episodes, service refusal, and medication refusal.	80%	84.8%
6	FOR DDD MEMBERS ONLY: Individuals with identified specialized service needs are referred for and receive these services.	85%	100%
7	The individual has an assigned clinician.	80%	99.3%
8	The assigned clinician is actively involved in the oversight of the treatment.	80%	100%
14	The disposition of the referral from the PCP or Health Plan is communicated to the PCP or Health Plan within 30 days of receiving the request for service.	60%	62.5%
18	Service plans and/or services are revised based on progress or lack of progress in the individual's behavioral health condition.	70%	91.3%
19	Service plans and/or services are revised based on significant changes in the individual's behavioral health condition.	70%	90.3%
20	The treatment plan incorporates the identified needs of the individual, includes measurable goals which address those needs, and describes specific action steps to reasonably accomplish the goals.	80%	98.8%
21	Services are provided in a timeframe responsive to the urgency of the member's need.	85%	98.0%

For Children:

PGBHA met or exceeded the following minimum performance scores:

#	ICR Standard	Minimum Performance Score	PGBHA Results Children
1	Assessments are sufficiently comprehensive for the development of functional treatment recommendations.	85%	88.0%
2	The types and intensity of services are provided based upon the needs identified in the individual's assessment and treatment recommendations.	85%	93.5%
3	Staff actively engage the following in the treatment planning process: individual, family, and other agencies.	85%	92.3%
4	Case management services are provided based on the individual's assessment and treatment recommendations.	85%	98.9%
6	FOR DDD MEMBERS ONLY: Individuals with identified specialized service needs are referred for and receive these services.	85%	100%
7	The individual has an assigned clinician.	80%	97.8%
8	The assigned clinician is actively involved in the oversight of the treatment.	80%	98.9%
12	If the individual has been prescribed psychotropic medication and adverse reactions or side effects are noted, progress notes include documentation of follow-up actions to address adverse effects.	85%	85.7%
16	There is evidence of symptomatic improvement.	80%	84.9%
17	There is evidence of functional improvement.	80%	81.6%
18	Service plans and/or services are revised based on progress or lack of progress in the individual's behavioral health condition.	70%	90.2%
19	Service plans and/or services are revised based on significant changes in the individual's behavioral health condition.	70%	85.4%
20	The treatment plan incorporates the identified needs of the individual, includes measurable goals which address those needs, and describes specific action steps to reasonably accomplish the goals.	80%	94.7%
21	Services are provided in a timeframe responsive to the urgency of the member's need.	85%	95.7%

Areas of Concern: PGBHA results were below the minimum performance scores on Standard 9, which addresses cultural preferences, but still exceeded the GSA statewide score. PGBHA scored 27.3 percent for adults and 25.0 percent for children. PGBHA's overall scoring on medication Standards 10–12 was low. Standard 15, which addresses collaboration with the PCP, scored 57.4 percent for adults and 43.3 percent for children. Although PGBHA exceeded the minimum performance scores for children on Standards 16 and 17, addressing outcomes, the adult score was lower at 73.8 percent for both standards.

#	ICR Standard	Minimum Performance Score	PGBHA Results	
			Adults	Children
9	Individuals'/families' cultural preferences are assessed and included in the development of treatment plans.	70%	27.3%	25.0%
10	Individuals and/or parent/guardians are informed about and give consent for prescribed medications.	80%	73.6%	64.7%
11	If the individual has been prescribed anti-psychotic medication, regular assessments for movement disorders are documented.	70%	62.0%	53.3%
12	If the individual has been prescribed psychotropic medication and adverse reactions or side effects are noted, progress notes include documentation of follow-up actions to address adverse effects.	85%	77.5%	85.7%*
15	Behavioral health care has been communicated or attempts have been made to coordinate with the PCP in the following circumstances: initial assessment and treatment recommendations; initiation and significant changes in psychotropic medications and significant adverse reactions; results of relevant laboratory, radiology and other tests; emergency/crisis admission or events; discharge from an inpatient setting; disenrollment from ADHS/RBHA; and any other events requiring medical consultation with the individual's PCP.	60%	57.4%	43.3%
16	There is evidence of symptomatic improvement.	80%	73.8%	84.9%*
17	There is evidence of functional improvement.	80%	73.8%	81.6%*

*Although these results exceed the minimum performance score, they are provided for comparison purposes.

ValueOptions

Strengths: ValueOptions exceeded the minimum performance scores for both children and adults on Standard 1, addressing sufficiently comprehensive assessments. ValueOptions was the only GSA to meet minimum performance scores for both children and adults on Standard 11, which addresses regular assessments for movement disorders. ValueOptions was the leader in outcomes for children, scoring 92.7 percent for Standard 16 and 90.6 percent for Standard 17. ValueOptions also scored very high for children on Standard 20, addressing treatment planning. ValueOptions received a 99.0 percent score for children on Standard 21, which addresses services provided in a timeframe responsive to the urgency of the individual's need.

For Adults:

ValueOptions met or exceeded the following minimum performance scores:

#	ICR Standard	Minimum Performance Score	ValueOptions Results Adults
1	Assessments are sufficiently comprehensive for the development of functional treatment recommendations.	85%	89.4%
7	The individual has an assigned clinician.	80%	91.2%
8	The assigned clinician is actively involved in the oversight of the treatment.	80%	95.4%
11	If the individual has been prescribed anti-psychotic medication, regular assessments for movement disorders are documented.	70%	72.5%
20	The treatment plan incorporates the identified needs of the individual, includes measurable goals which address those needs, and describes specific action steps to reasonably accomplish the goals.	80%	90.0%
21	Services are provided in a timeframe responsive to the urgency of the member's need.	85%	90.0%

For Children:

ValueOptions met or exceeded the following minimum performance scores:

#	ICR Standard	Minimum Performance Score	ValueOptions Results Children
1	Assessments are sufficiently comprehensive for the development of functional treatment recommendations.	85%	89.0%
2	The types and intensity of services are provided based upon the needs identified in the individual's assessment and treatment recommendations.	85%	93.0%
4	Case management services are provided based on the individual's assessment and treatment recommendations.	85%	95.0%
5	Outreach/follow-up occurs after discharge from inpatient and from residential, missed appointments, crisis episodes, service refusal, and medication refusal.	80%	86.9%
6	FOR DDD MEMBERS ONLY: Individuals with identified specialized service needs are referred for and receive these services.	85%	98.1%
7	The individual has an assigned clinician.	80%	97.0%
8	The assigned clinician is actively involved in the oversight of the treatment.	80%	99.0%
11	If the individual has been prescribed anti-psychotic medication, regular assessments for movement disorders are documented.	70%	70.4%
12	If the individual has been prescribed psychotropic medication and adverse reactions or side effects are noted, progress notes include documentation of follow-up actions to address adverse effects.	85%	90.9%
16	There is evidence of symptomatic improvement.	80%	92.7%
17	There is evidence of functional improvement.	80%	90.6%
18	Service plans and/or services are revised based on progress or lack of progress in the individual's behavioral health condition.	70%	75.0%
19	Service plans and/or services are revised based on significant changes in the individual's behavioral health condition.	70%	75.0%
20	The treatment plan incorporates the identified needs of the individual, includes measurable goals which address those needs, and describes specific action steps to reasonably accomplish the goals.	80%	99.1%
21	Services are provided in a timeframe responsive to the urgency of the member's need.	85%	99.0%

Areas of Concern: There is a large discrepancy between adults and children regarding ValueOptions scores. Overall, ValueOptions met 15 out of 20 (75.0 percent) of the minimum performance scores for children, but only 6 out of 20 (30.0 percent) of the minimum performance scores for adults. ValueOptions had the lowest adult score on Standard 3, with a score of 70.5 percent. Standard 3b, which addresses the engagement of the family in the treatment planning process, was the lowest adult score at 32.4 percent. Standard 9, which addresses cultural preferences, was below the statewide average with 11.8 percent for adults and 16.0 percent for children. Standard 10, which addresses informed consent, did not meet the minimum performance score; however, with adults at 56.6 percent and children at 60.3 percent, they were above the statewide average. Standard 14, which addresses the disposition of the referral, was low, as well as Standard 15, which addresses collaboration with the PCP. The combined score for adults for Standards 16 and 17 is 56.5 percent, below the GSA statewide score of 73.3 percent.

#	ICR Standard	Minimum Performance Score	ValueOptions Results Adults	Children
3	Staff actively engage the following in the treatment planning process:	85%	70.5%	84.4%
	a. individual		89.9%*	78.0%
	b. family		32.4%	91.8%*
	c. other agencies		77.2%	83.5%
9	Individuals'/families' cultural preferences are assessed and included in the development of treatment plans.	70%	11.8%	16.0%
10	Individuals and/or parent/guardians are informed about and give consent for prescribed medications.	80%	56.6%	60.3%
14	The disposition of the referral from the PCP or Health Plan is communicated to the PCP or Health Plan within 30 days of receiving the request for service.	60%	36.4%	50.0%
15	Behavioral health care has been communicated or attempts have been made to coordinate with the PCP in the following circumstances: initial assessment and treatment recommendations; initiation and significant changes in psychotropic medications and significant adverse reactions; results of relevant laboratory, radiology and other tests; emergency/crisis admission or events; discharge from an inpatient setting; disenrollment from ADHS/RBHA; and any other events requiring medical consultation with the individual's PCP.	60%	40.5%	55.6%
16–17 Combined	There is evidence of symptomatic and functional improvement.	80%	58.3%	91.6%*
16	There is evidence of symptomatic improvement.	80%	59.6%	92.7%*
17	There is evidence of functional improvement.	80%	53.4%	90.6%*

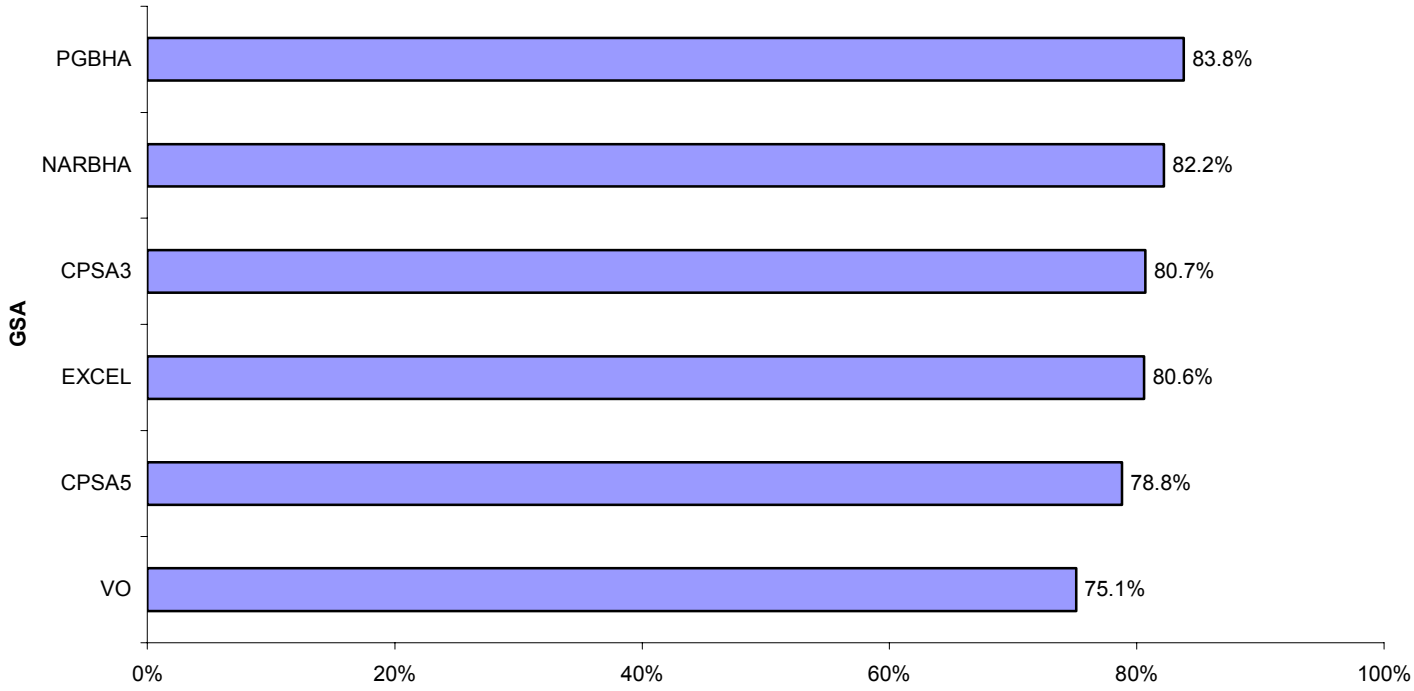
*Although these results exceed the minimum performance score, they are provided for comparison purposes.

Comparison by Geographic Service Area for Adults and Children

Overall Performance by GSA

The overall performance scores ranged from a low of 75.1 percent for ValueOptions to a high of 83.8 percent for PGBHA. The results for the remaining GSAs were close to the statewide performance score of 80.1 percent.

Figure 5-1—ADHS Independent Case Review 2002:
Overall Performance by GSA for Adults and Children

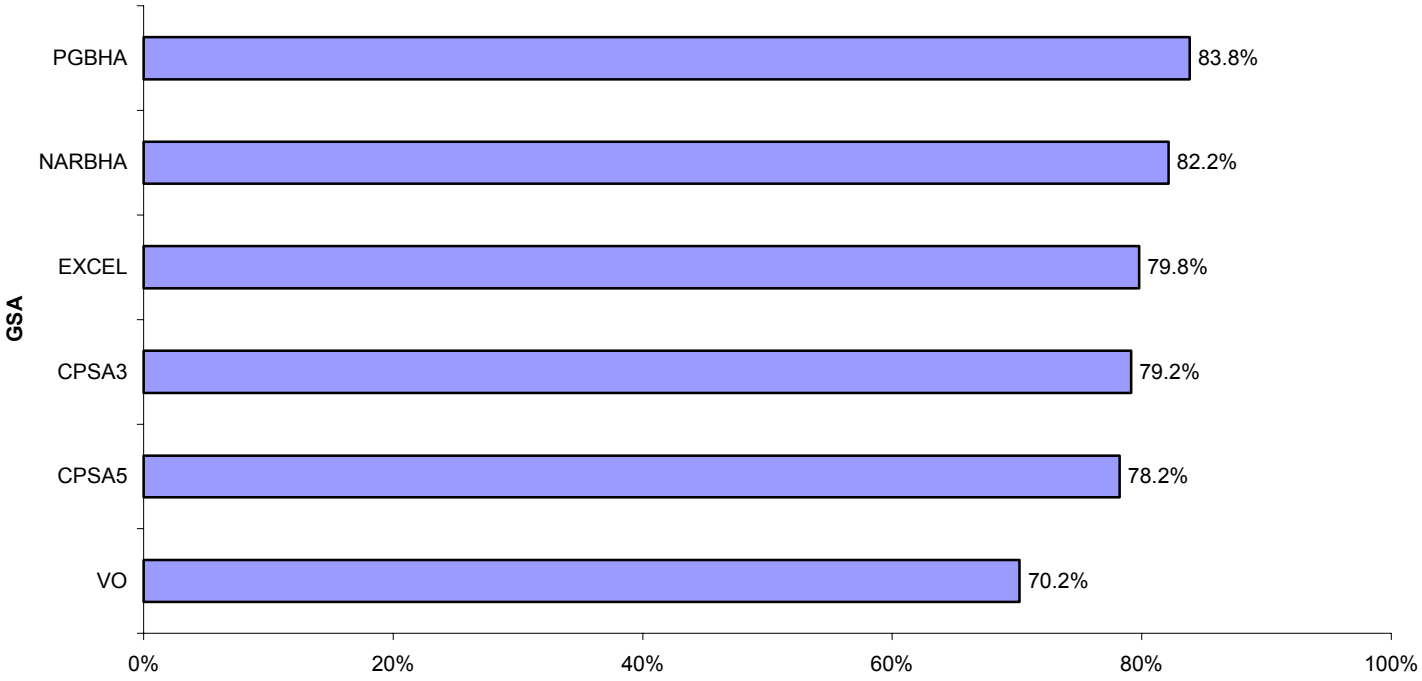


Note: The overall statewide performance score is 80.1 percent.

Overall Performance for Adults

The overall performance scores for the adult population ranged from a low of 70.2 percent for ValueOptions to a high of 83.8 percent for PGBHA. The remaining GSA scores were close to 80.0 percent.

Figure 5-2—ADHS Independent Case Review 2002:
Comparison of Overall Performance by GSA for Adults

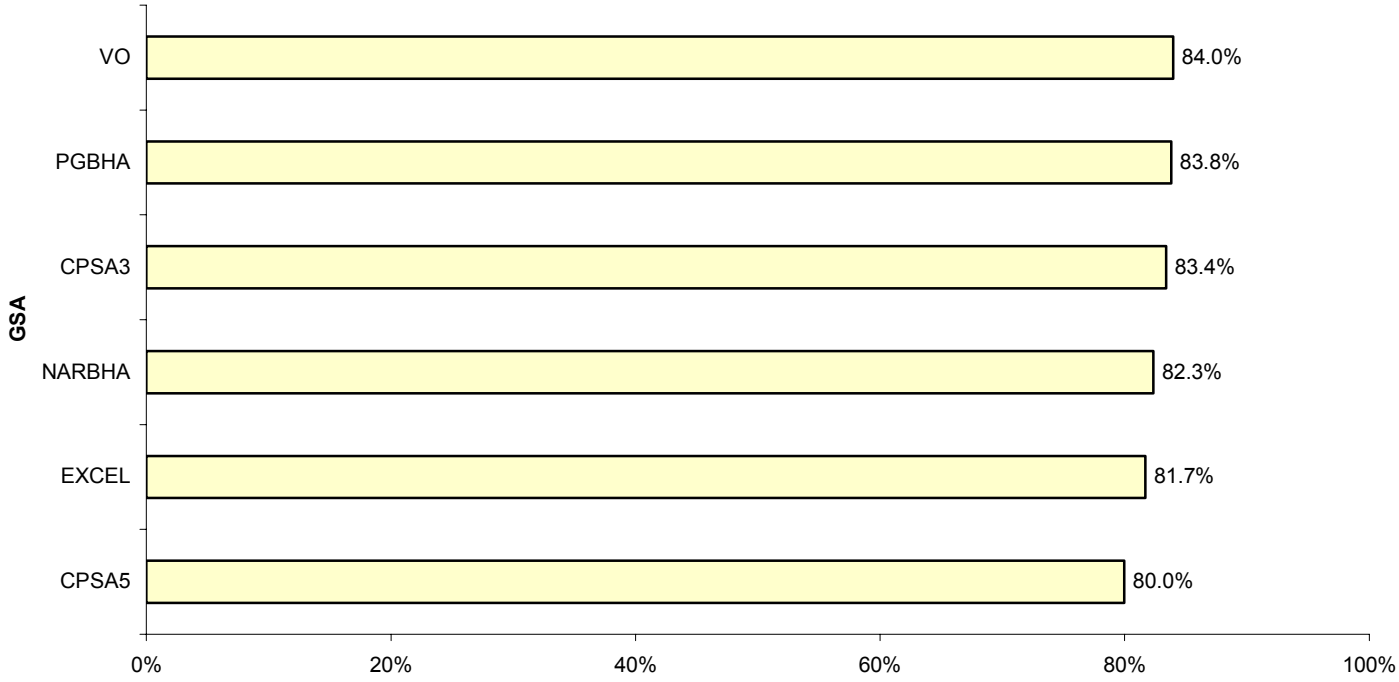


Note: The statewide performance score for adults is 78.6 percent.

Overall Performance for Children

The overall performance scores for the child population ranged from a low of 80.0 percent for CPSA-5 to a high of 84.0 percent for ValueOptions. The remaining GSA scores were close to the statewide performance score of 82.5 percent.

Figure 5-3—ADHS Independent Case Review 2002:
Comparison of Overall Performance by GSA for Children



Note: The statewide performance score for children is 82.5 percent.

6. Summary Comparison of SMI and Non-SMI

This section presents a comparison of results specific to the level of mental illness: seriously mentally ill (SMI) and non-SMI. Table 6-1 displays statewide scores by standard for individuals identified as SMI and individuals identified as non-SMI.

The original sample was selected for adults and children by GSA without consideration for the level of mental illness. As a result, the sample size differs for SMI and non-SMI. The sample size for the SMI was 344 cases, while 612 cases were non-SMI. Sample sizes for each standard are provided in the graphs in Appendix B and the tables in Appendix C.

Table 6-1—ADHS Independent Case Review 2002: Results of ICR Standards 1-21 for SMI and Non-SMI

#	ICR Standard	Minimum Performance Score	Statewide Results	
			SMI	Non-SMI
1	Assessments are sufficiently comprehensive for the development of functional treatment recommendations.	85%	87.8%	88.2%
2	The types and intensity of services are provided based upon the needs identified in the individual's assessment and treatment recommendations.	85%	92.2%	89.9%
3	Staff actively engage the following in the treatment planning process:	85%	83.7%	83.5%
	a. individual		95.6%	96.2%
	b. family		54.4%	44.1%
	c. other agencies		87.3%	87.9%
4	Case management services are provided based on the individual's assessment and treatment recommendations.	85%	94.4%	92.2%
5	Outreach/follow-up occurs after:	80%	86.3%	70.4%
	a. discharge from inpatient		98.6%	87.8%
	b. discharge from residential		88.9%	64.3%
	c. missed appointments		81.0%	67.9%
	d. crisis episodes		93.3%	84.6%
	e. service refusal		75.0%	59.5%
	f. medication refusal		87.1%	75.0%
6	FOR DDD MEMBERS ONLY: Individuals with identified specialized service needs are referred for and receive these services.	85%	100.0%	78.8%
7	The individual has an assigned clinician	80%	97.7%	96.9%
8	The assigned clinician is actively involved in the oversight of the treatment.	80%	96.7%	96.5%
9	Individuals'/families' cultural preferences are assessed and included in the development of treatment plans.	70%	14.0%	20.8%

Table 6-1—ADHS Independent Case Review 2002: Results of ICR Standards 1-21 for SMI and Non-SMI				
#	ICR Standard	Minimum Performance Score	Statewide Results	
			SMI	Non-SMI
10	Individuals and/or parent/guardians are informed about and give consent for prescribed medications.	80%	59.1%	48.1%
11	If the individual has been prescribed anti-psychotic medication, regular assessments for movement disorders are documented.	70%	63.3%	50.7%
12	If the individual has been prescribed psychotropic medication and adverse reactions or side effects are noted, progress notes include documentation of follow-up actions to address adverse effects.	85%	85.3%	78.5%
13	If the individual has been prescribed psychotropic medication, the record includes documentation of specific target symptoms.	No Minimum Performance Score	63.1%	63.2%
14	The disposition of the referral from the PCP or Health Plan is communicated to the PCP or Health Plan within 30 days of receiving the request for service.	60%	64.3%	70.5%
15	Behavioral health care has been communicated or attempts have been made to coordinate with the PCP in the following circumstances:	60%	54.0%	51.2%
	a. initial assessment and treatment recommendations		62.0%	63.5%
	b. initiation and significant changes in psychotropic medications and significant adverse reactions		61.9%	49.6%
	c. results of relevant laboratory, radiology and other tests		54.5%	45.5%
	d. emergency/crisis admission or events		30.9%	31.4%
	e. discharge from an inpatient setting		25.0%	29.5%
	f. disenrollment from ADHS/RBHA		14.3%	18.2%
	g. any other events requiring medical consultation with the individual's PCP		70.4%	65.0%
16	There is evidence of symptomatic improvement.	80%	79.0%	71.5%
17	There is evidence of functional improvement.	80%	75.4%	70.1%
18	Service plans and/or services are revised based on progress or lack of progress in the individual's behavioral health condition.	70%	77.2%	73.5%
19	Service plans and/or services are revised based on significant changes in the individual's behavioral health condition.	70%	76.6%	68.6%
20	The treatment plan:	80%	95.1%	96.1%
	a. incorporates the identified needs of the individual		93.7%	96.8%
	b. includes measurable goals which address those needs		94.7%	95.3%
	c. describes specific action steps to reasonably accomplish the goals		96.8%	96.1%
21	Services are provided in a timeframe responsive to the urgency of the member's need.	85%	95.1%	94.1%

Findings

For SMI individuals, the statewide results met or exceeded 13 of 20 minimum performance scores. For non-SMI individuals, the statewide results met or exceeded 9 of 20 minimum performance scores (see Appendix B).

Statewide, the results for SMI and non-SMI for 15 out of the 20 standards were not statistically different. However, there were five standards that could be identified as having a statistically significant variance between SMI and non-SMI scores. For four of these standards, the SMI score was higher than the non-SMI score (presented below). Standard 9, however, was the one standard for which the SMI score was lower than the non-SMI score (see next page).

Higher SMI Scores

Standard 5

Although the minimum performance score of 80 percent was not met for the non-SMI population, it was exceeded in the SMI population with a score of 86.3 percent. The higher score for the SMI sample would be an expected result on the measurement of outreach, as the SMI population generally receives a higher level of case management.

#	ICR Standard	Minimum Performance Score	Statewide Results	
			SMI	Non-SMI
5	Outreach/follow-up occurs after discharge from inpatient and from residential, missed appointments, crisis episodes, service refusal, and medication refusal.	80%	86.3%	70.4%

Standard 10

The minimum performance score of 80 percent was not met for either the SMI or the non-SMI population; however, the score was highest for the SMI population at 59.1 percent. The non-SMI population score was 48.1 percent.

#	ICR Standard	Minimum Performance Score	Statewide Results	
			SMI	Non-SMI
10	Individuals and/or parent/guardians are informed about and give consent for prescribed medications.	80%	59.1%	48.1%

Standard 11

The 63.3 percent score for SMI sample was higher than the non-SMI score of 50.7 percent; however, neither score met the minimum performance score of 70 percent. The higher SMI score could be expected due to the fact that the SMI population may be more likely to be prescribed anti-psychotic medications with higher incidence of movement disorders.

#	ICR Standard	Minimum Performance Score	Statewide Results	
			SMI	Non-SMI
11	If the individual has been prescribed anti-psychotic medication, regular assessments for movement disorders are documented.	70%	63.3%	50.7%

Standard 16 and Standard 17 Combined

The 77.2 percent SMI score for outcomes was higher than the 70.8 percent non-SMI score, although neither category met the minimum performance score of 80 percent.

#	ICR Standard	Minimum Performance Score	Statewide Results	
			SMI	Non-SMI
16–17 Combined	There is evidence of symptomatic and functional improvement.	80%	77.2%	70.8 %
16	There is evidence of symptomatic improvement.	80%	79.0%	71.5%
17	There is evidence of functional improvement.	80%	75.4%	70.1%

Lower SMI Score

Statewide, only Standard 9 received a lower score for the SMI population versus the non-SMI population.

Standard 9

With a minimum performance score of 70 percent, the SMI population had a 14.0 percent score, with the non-SMI population at 20.8 percent.

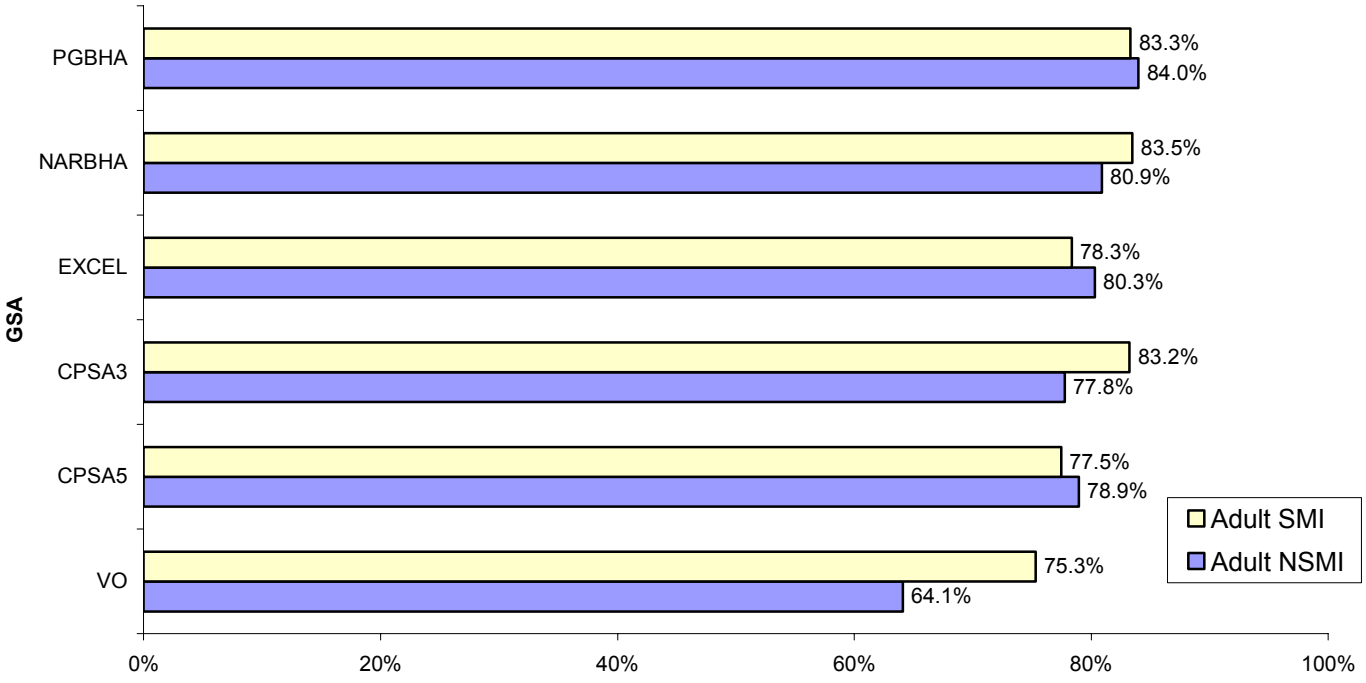
#	ICR Standard	Minimum Performance Score	Statewide Results	
			SMI	Non-SMI
9	Individuals'/families' cultural preferences are assessed and included in the development of treatment plans.	70%	14.0%	20.8%

Comparison by Geographic Service Area for SMI and Non-SMI

Overall Performance by GSA

Overall performance scores by GSA were similar for the SMI and non-SMI populations (Figure 6-1). For the SMI population, overall performance scores ranged from a low of 75.3 percent for ValueOptions to a high of 83.5 percent for NARBHA. The overall performance scores for the non-SMI population ranged from 64.1 percent for ValueOptions to 84.0 percent for PGBHA. Three GSAs had higher overall performance scores for the SMI population.

Figure 6-1—ADHS Independent Case Review 2002:
Comparison of Overall Performance by GSA for SMI and Non-SMI



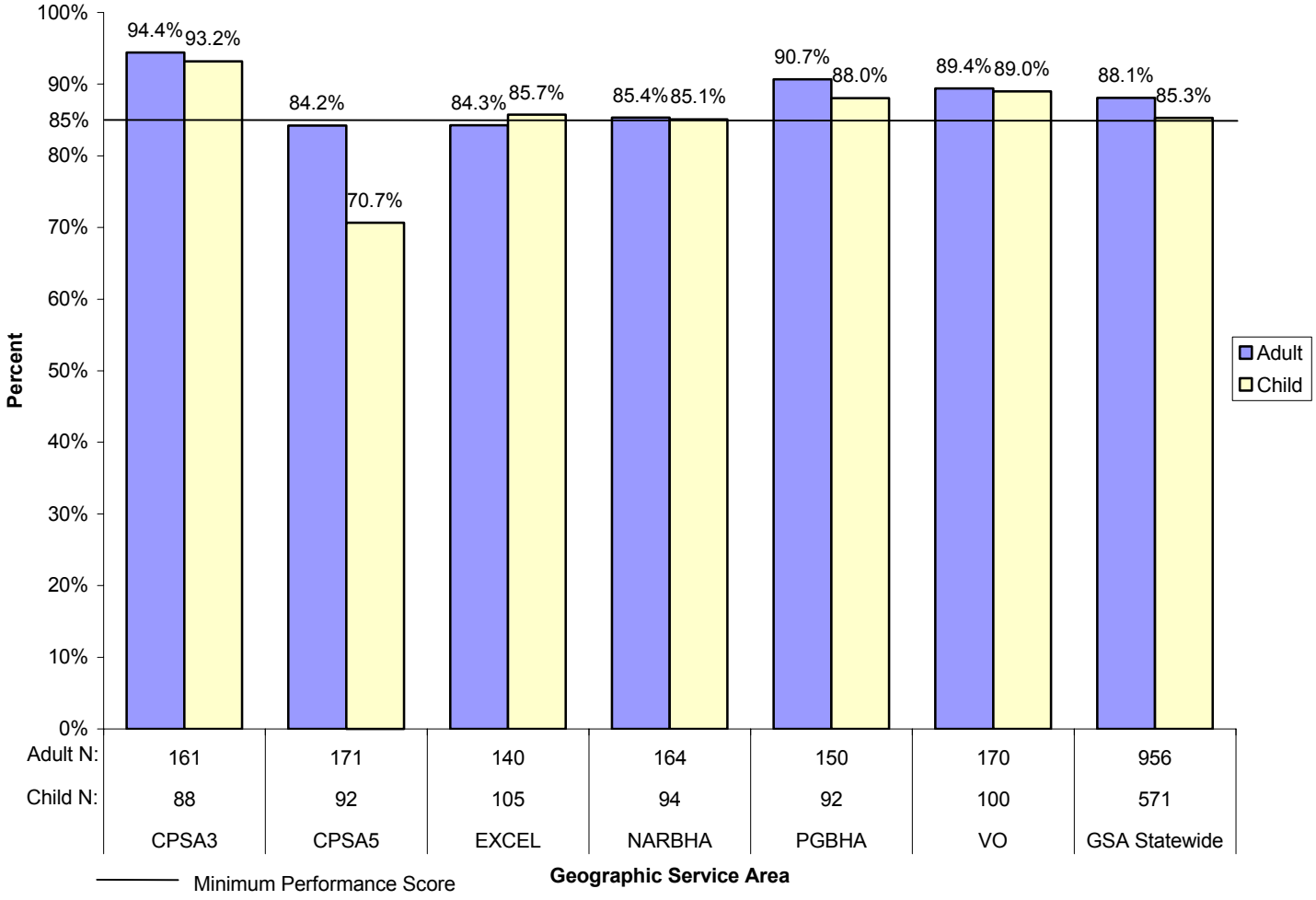
Note: The statewide performance score is 79.5 percent for SMI and 78.1 percent for non-SMI.

APPENDIX A. Adult and Child Graphs by GSA

Appendix A contains the bar graphs for each of the standards, illustrating the adult and child results for that standard by GSA.

Standard 1

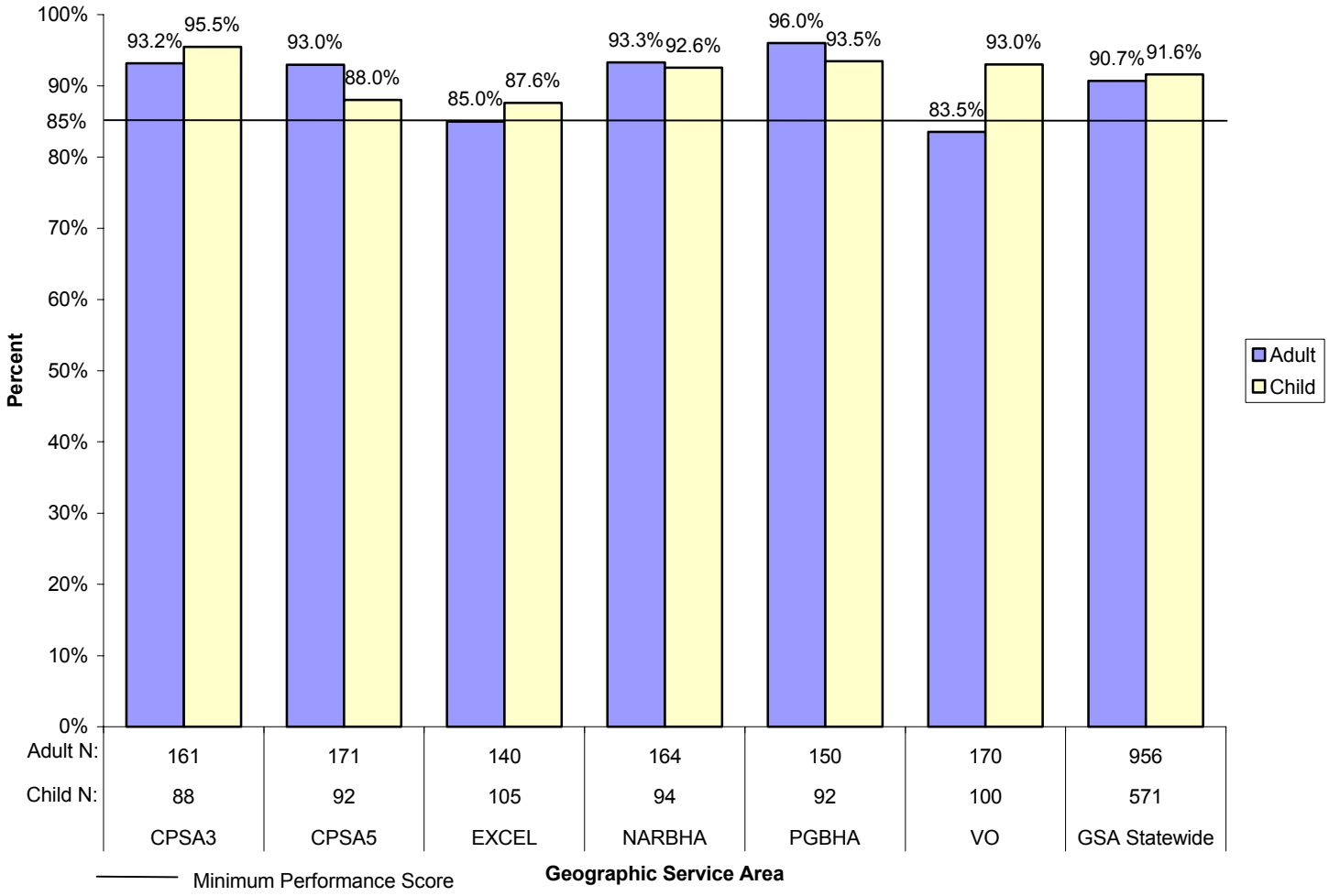
Figure A-1—ADHS Independent Case Review 2002: Standard 1



Standard 1 Assessments are sufficiently comprehensive for the development of functional treatment recommendations.

Standard 2

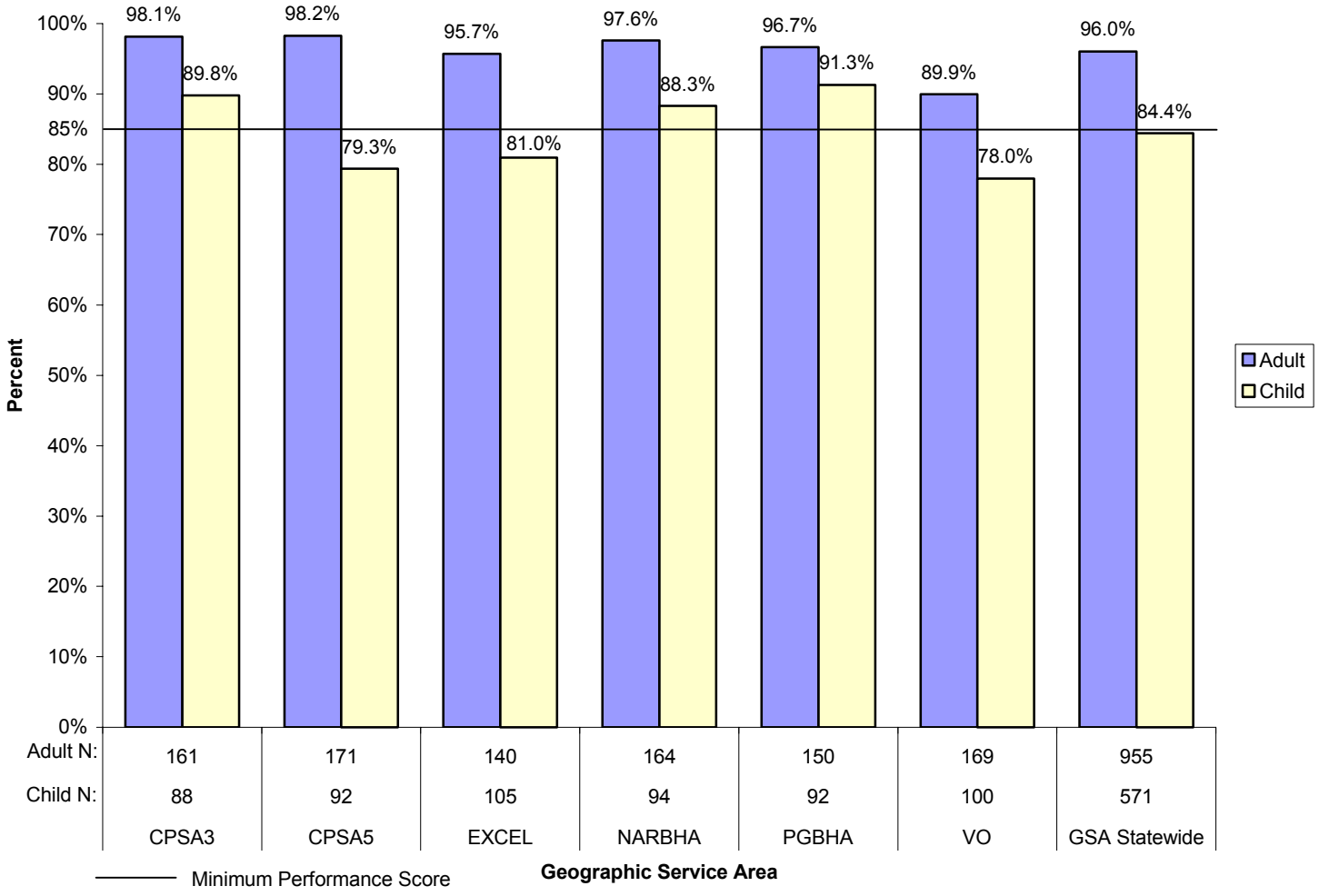
Figure A-2—ADHS Independent Case Review 2002: Standard 2



Standard 2 The types and intensity of services are provided based upon the needs identified in the individual's assessment and treatment recommendations.

Standard 3a

Figure A-3—ADHS Independent Case Review 2002: Standard 3a

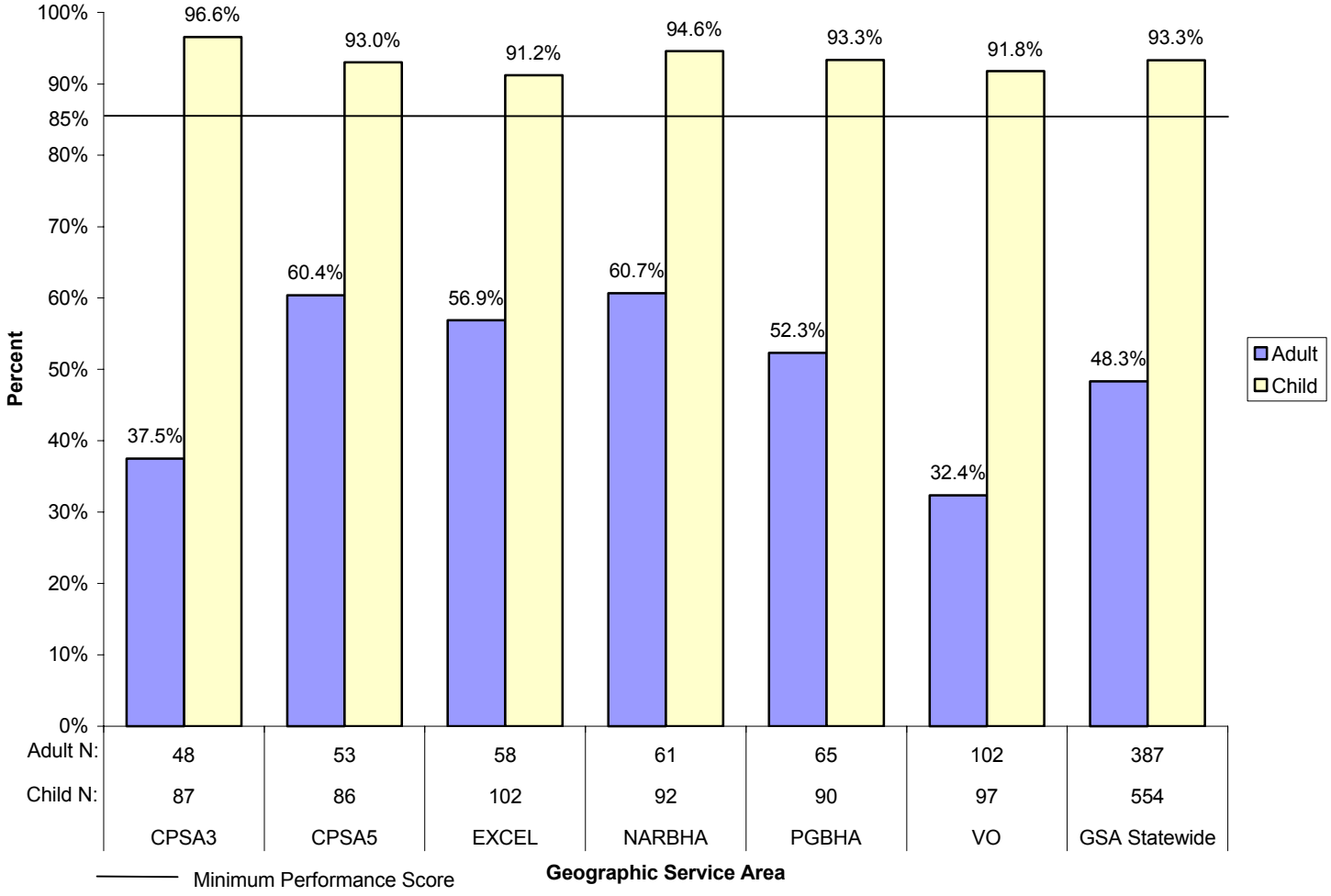


Standard 3a Staff actively engage the following in the treatment planning process:

a. Individual

Standard 3b

Figure A-4—ADHS Independent Case Review 2002: Standard 3b

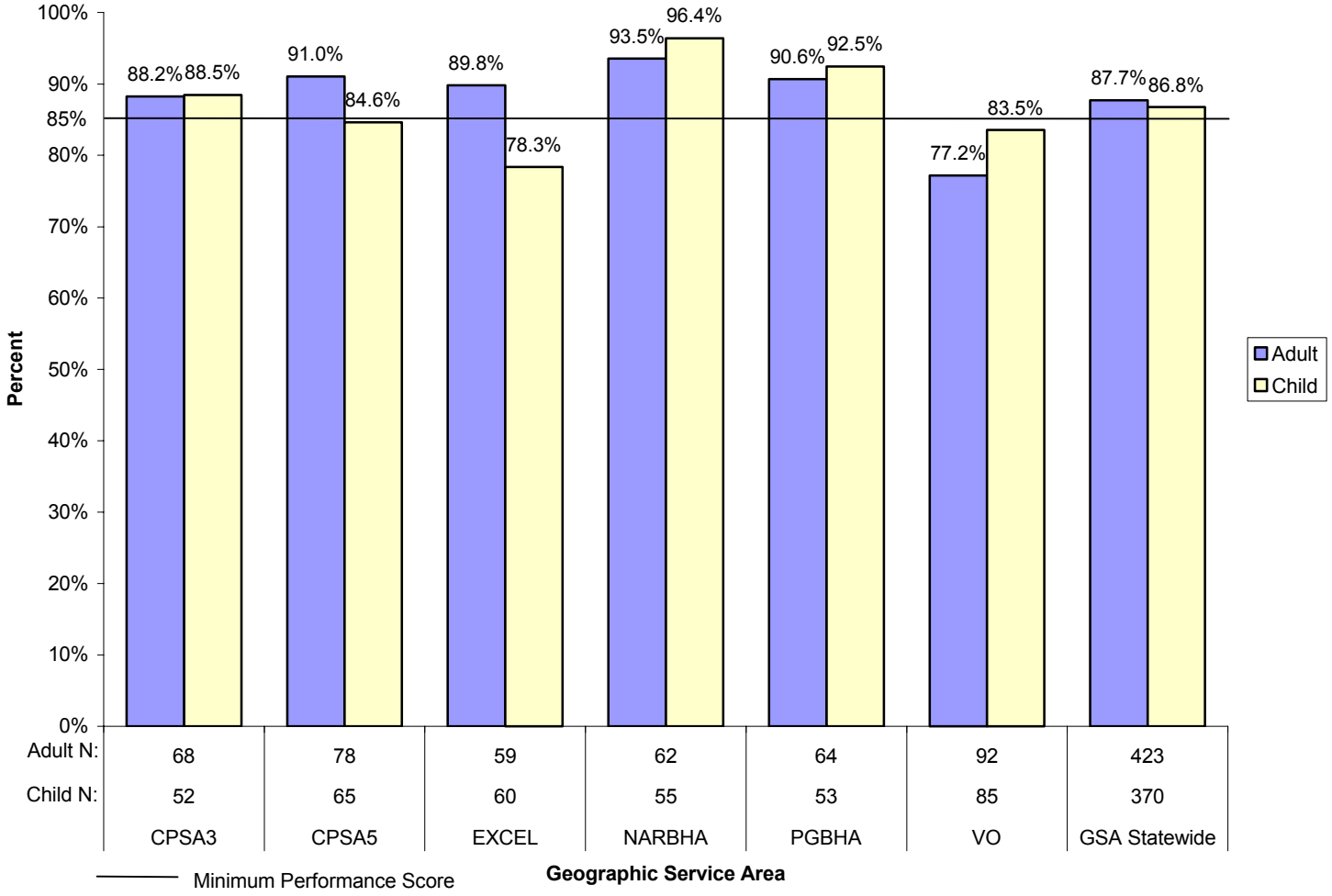


Standard 3b Staff actively engage the following in the treatment planning process:

b. Family

Standard 3c

Figure A-5—ADHS Independent Case Review 2002: Standard 3c

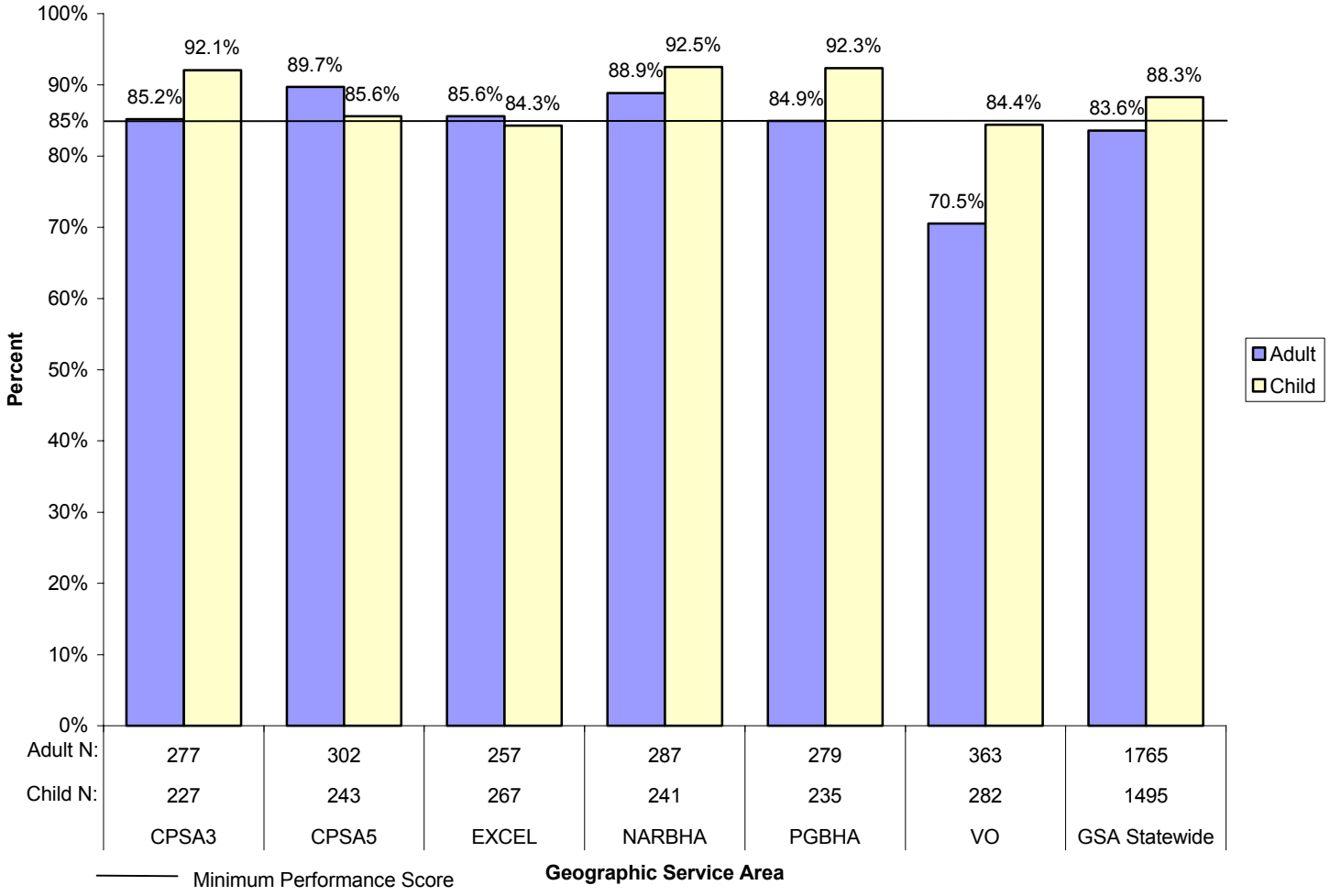


Standard 3c Staff actively engage the following in the treatment planning process:

c. Other agencies

Standard 3a–c

Figure A-6—ADHS Independent Case Review 2002: Standard 3a–c



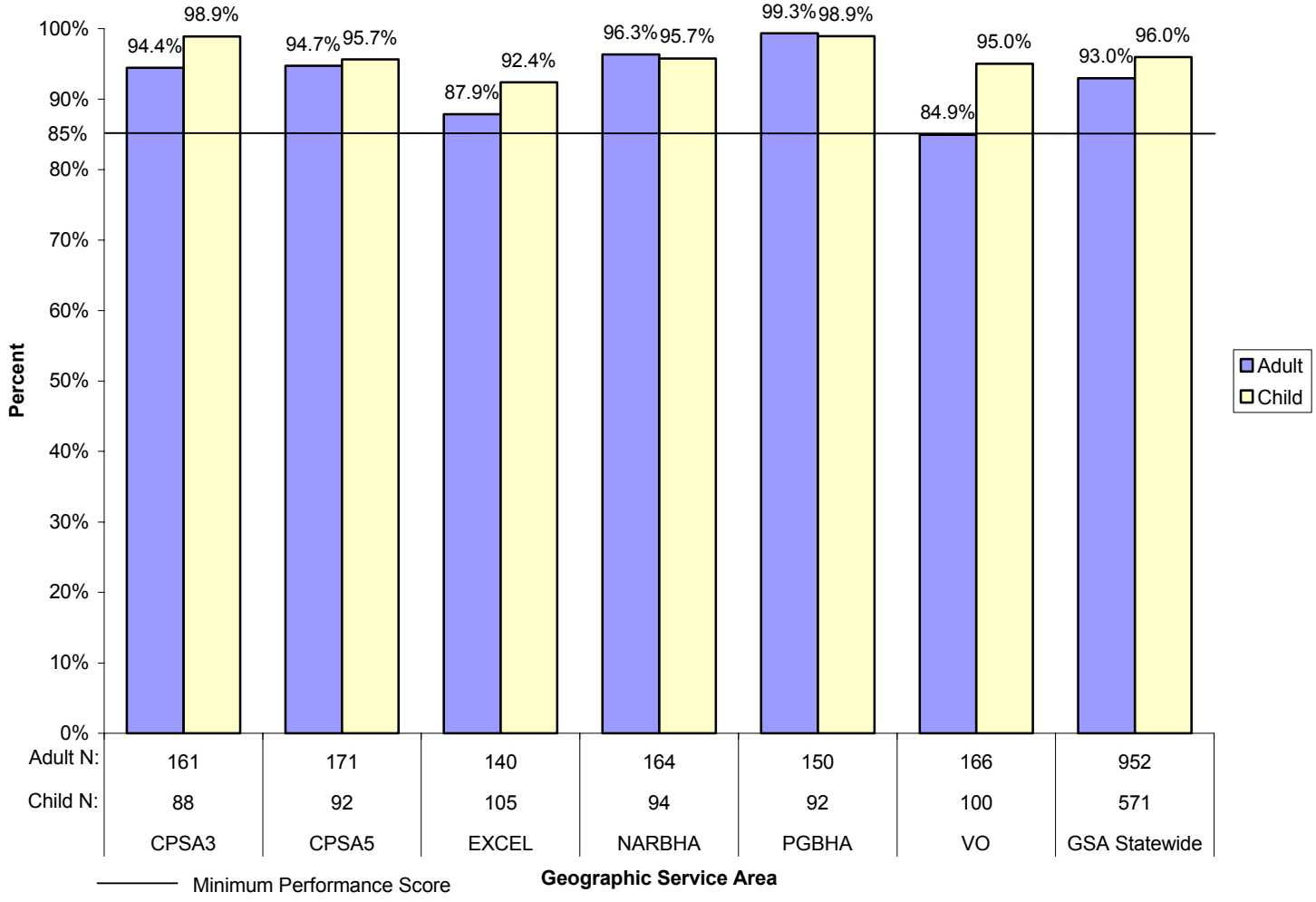
Standard 3a–c

Staff actively engage the following in the treatment planning process:

a. Individual
b. Family
c. Other agencies

Standard 4

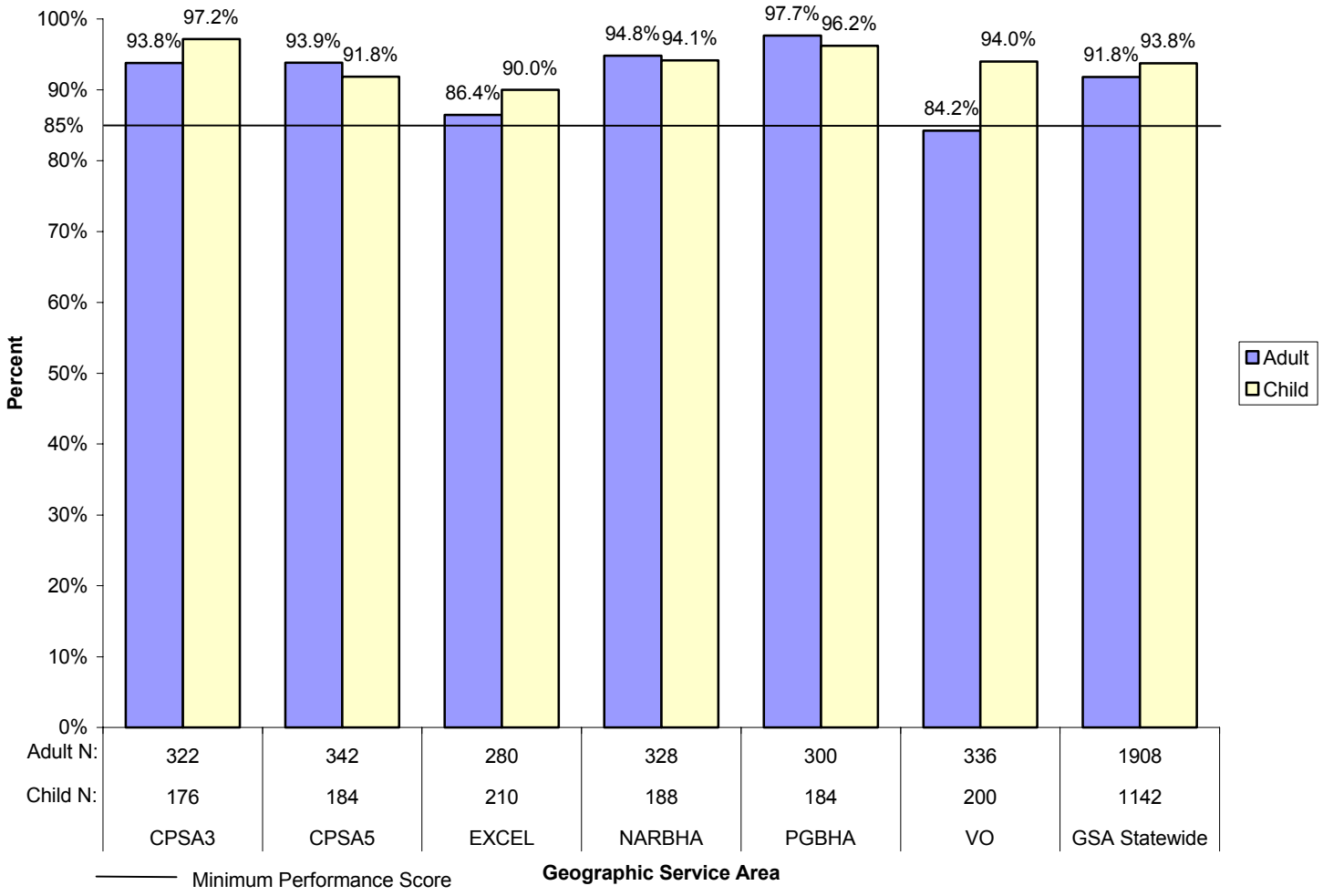
Figure A-7—ADHS Independent Case Review 2002: Standard 4



Standard 4 | Case management services are provided based on the individual's assessment and treatment recommendations.

Standards 2 and 4

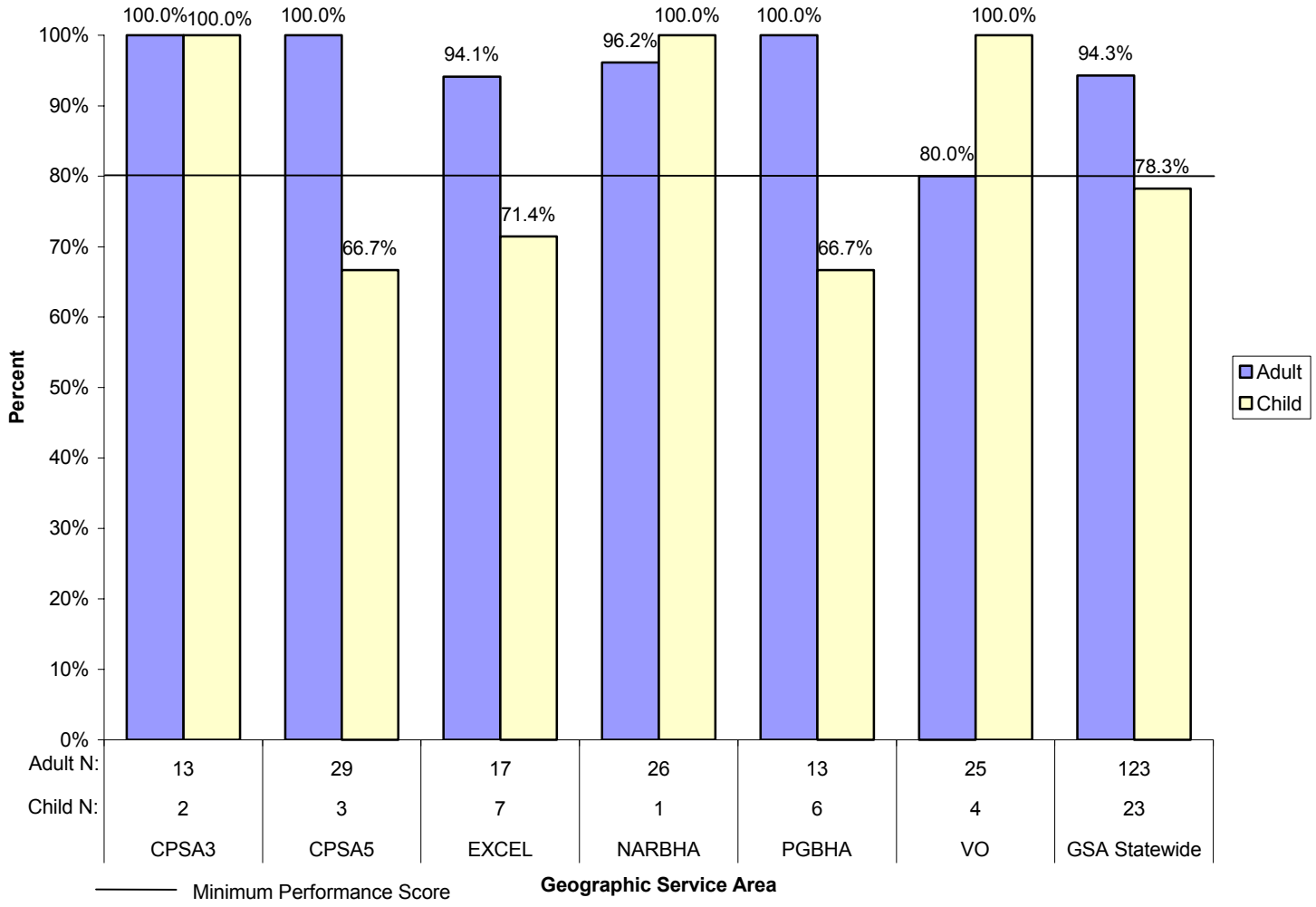
Figure A-8—ADHS Independent Case Review 2002: Standards 2 and 4



Standards 2 & 4 | This chart is the roll-up of Standards 2 and 4.

Standard 5a

Figure A-9—ADHS Independent Case Review 2002: Standard 5a



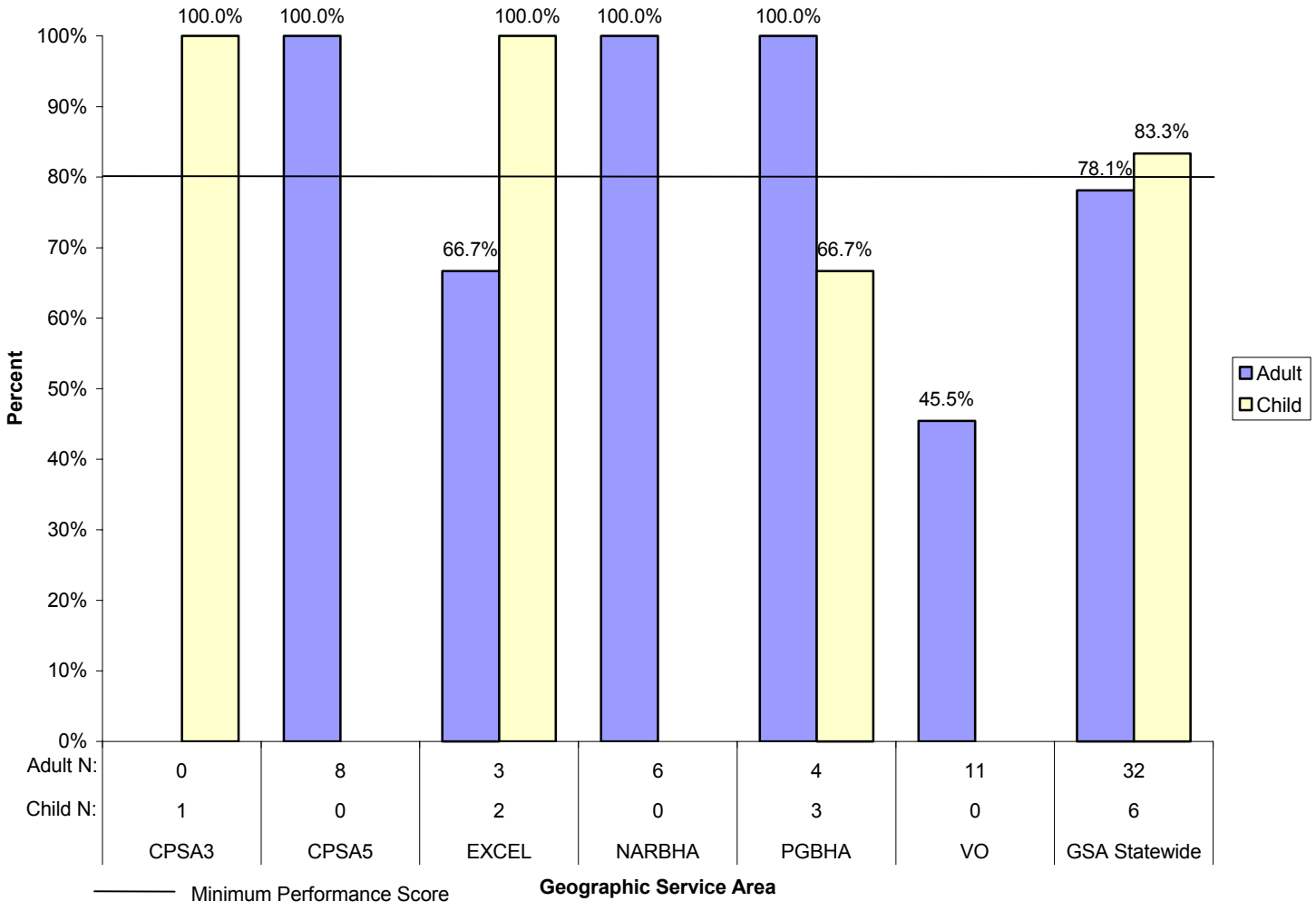
Standard 5a

Outreach/follow-up occurs after:

a. Discharge from inpatient

Standard 5b

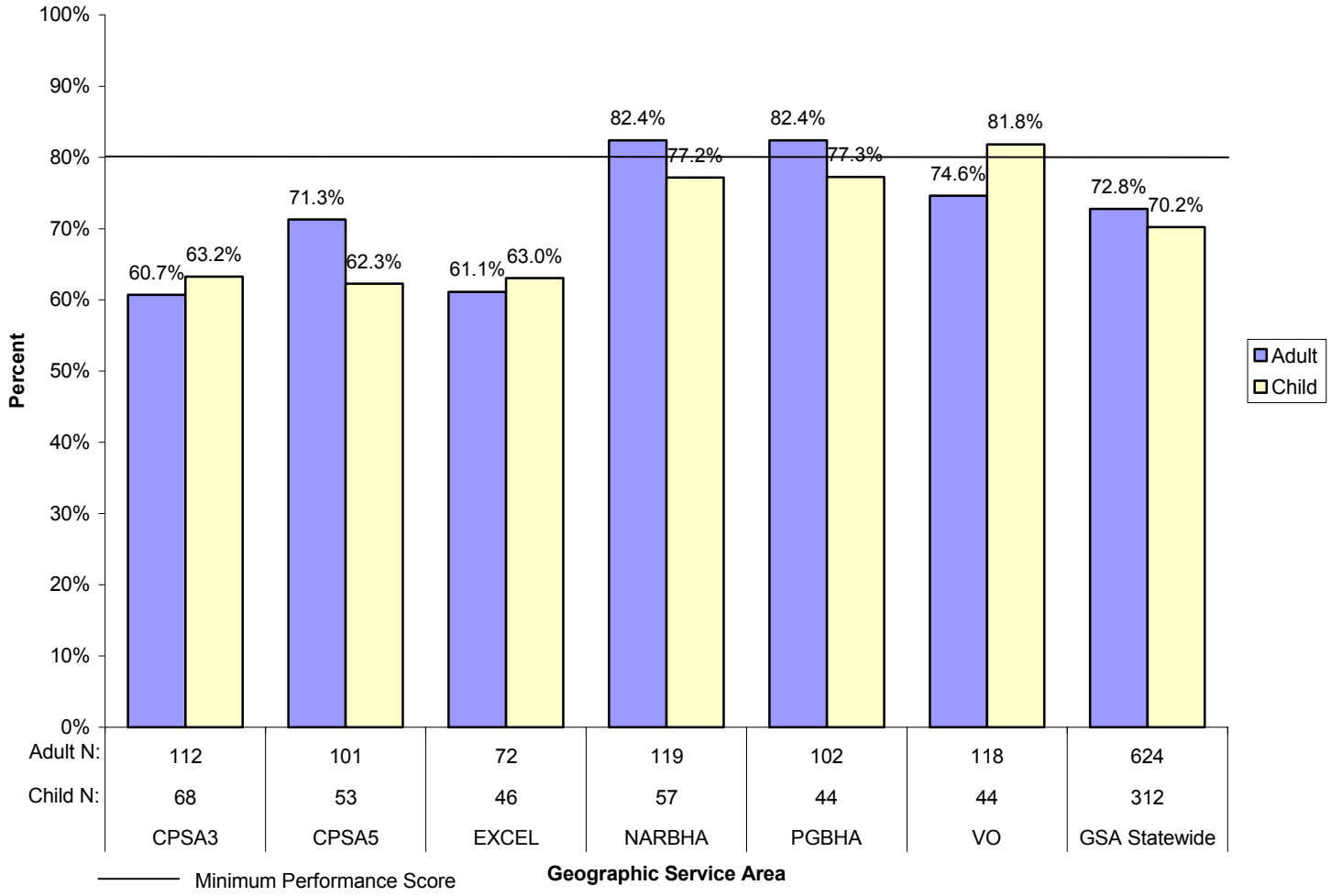
Figure A-10—ADHS Independent Case Review 2002: Standard 5b



Standard 5b | Outreach/follow-up occurs after:
b. Discharge from residential

Standard 5c

Figure A-11—ADHS Independent Case Review 2002: Standard 5c

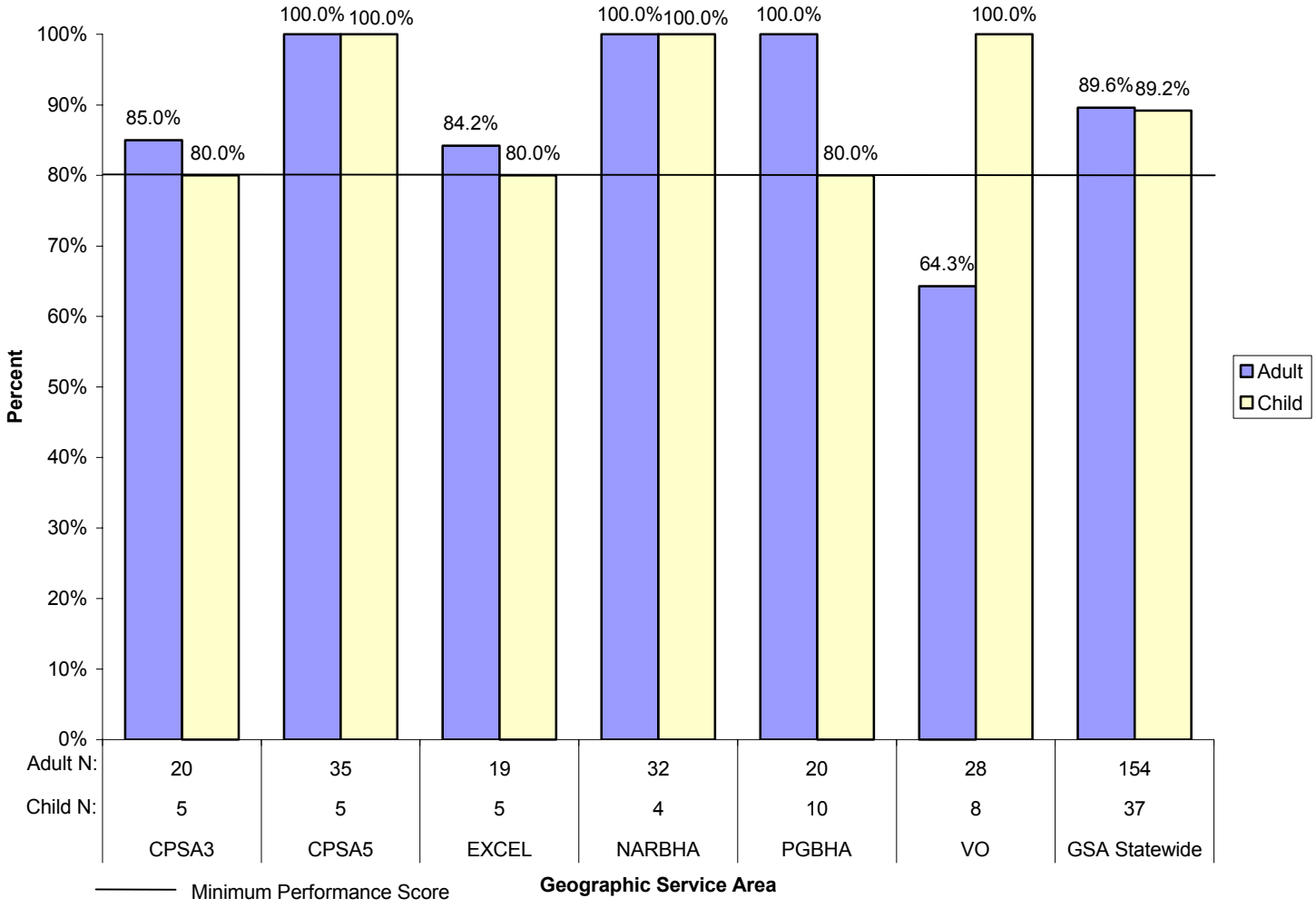


Standard 5c Outreach/follow-up occurs after:

c. Missed appointments

Standard 5d

Figure A-12—ADHS Independent Case Review 2002: Standard 5d



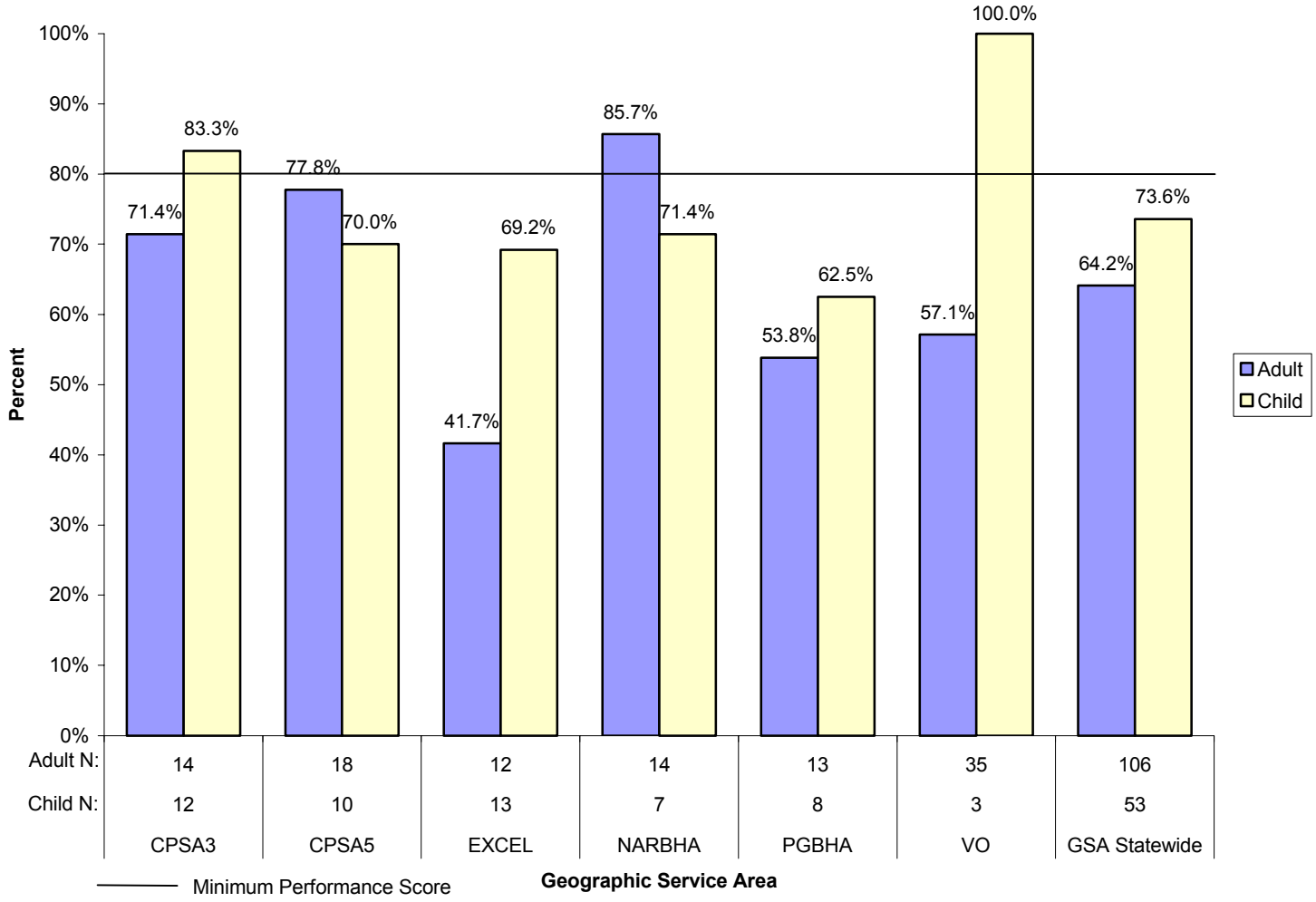
Standard 5d

Outreach/follow-up occurs after:

d. Crisis episodes

Standard 5e

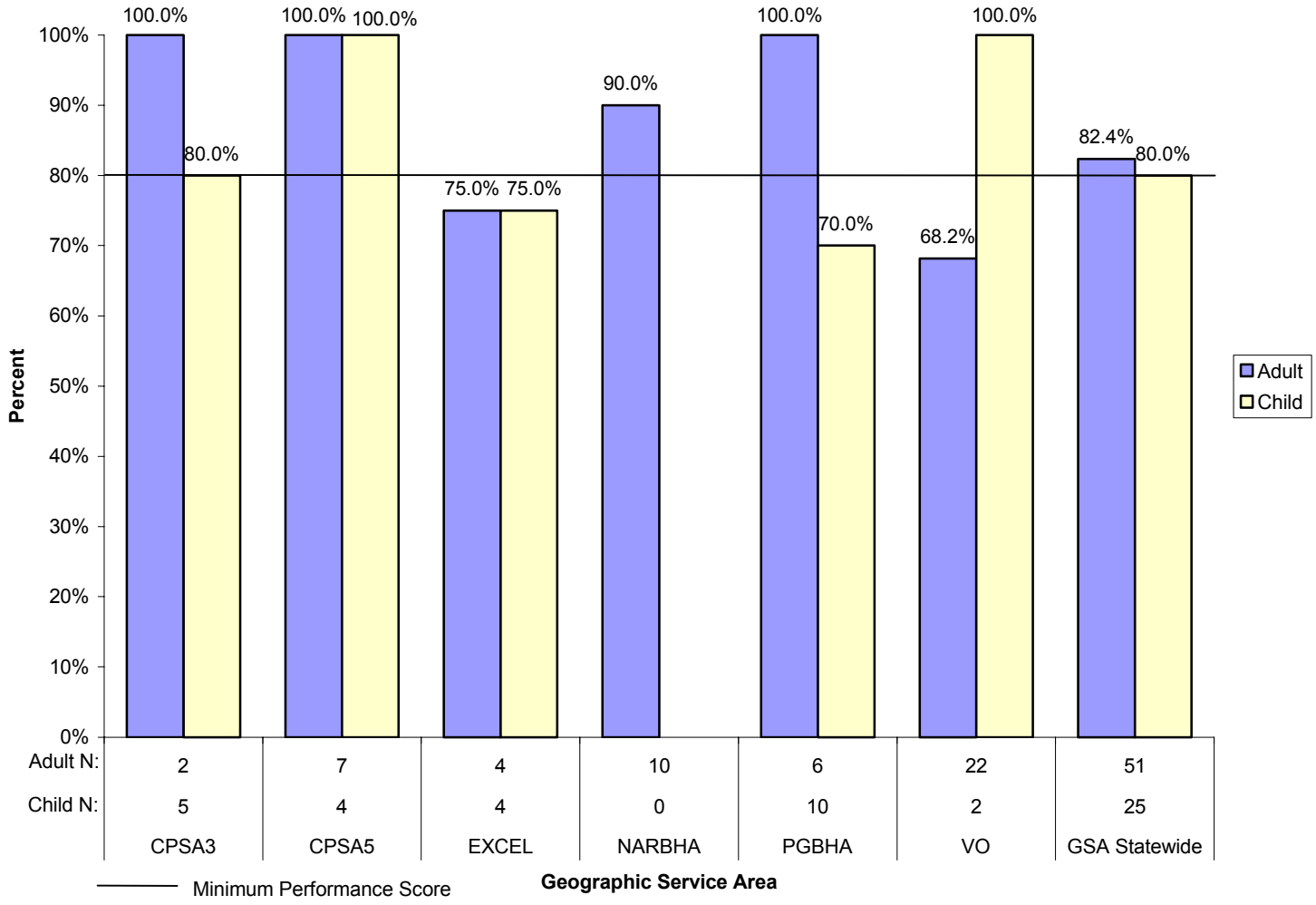
Figure A-13—ADHS Independent Case Review 2002: Standard 5e



Standard 5e	Outreach/follow-up occurs after: e. Service refusal

Standard 5f

Figure A-14—ADHS Independent Case Review 2002: Standard 5f

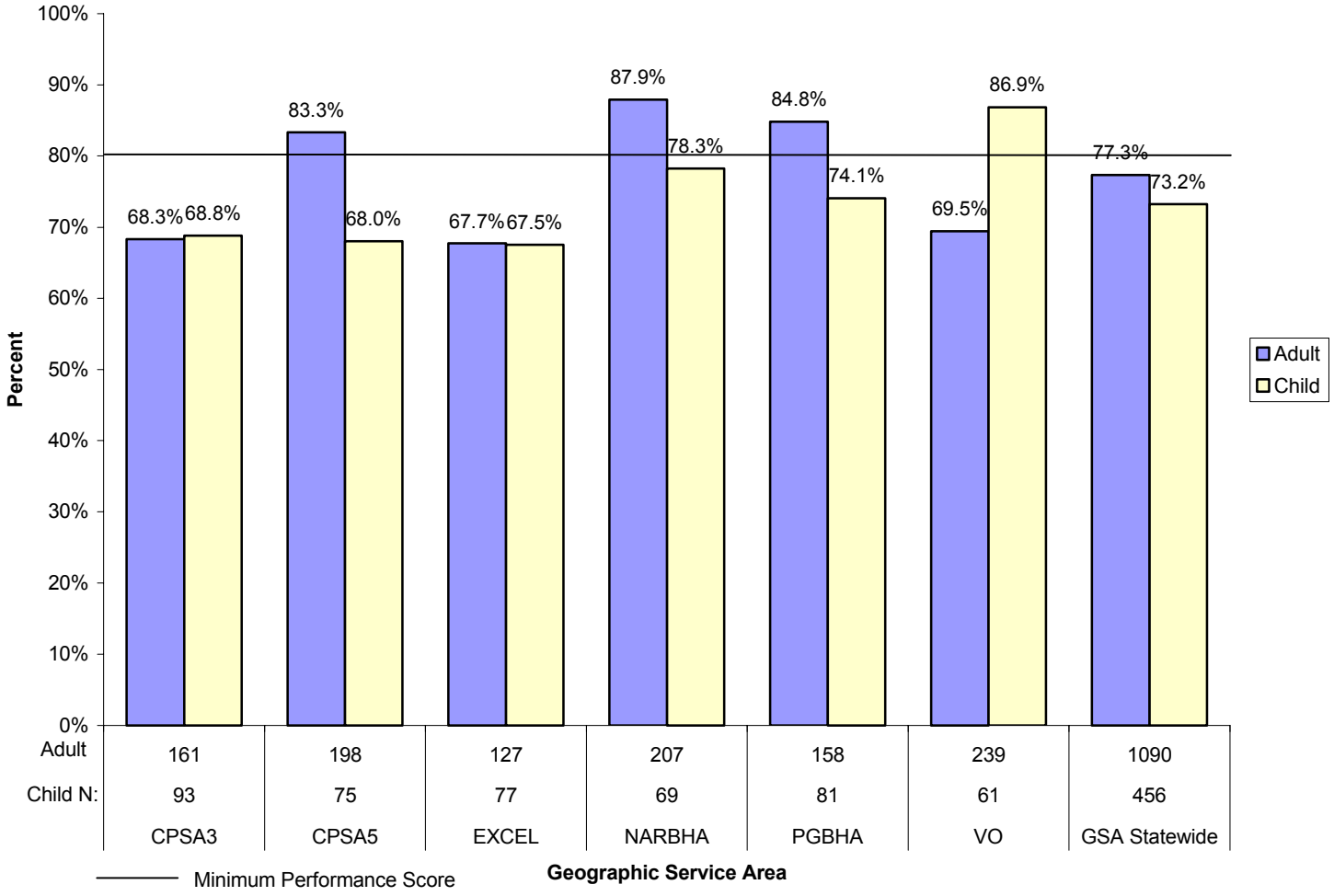


Standard 5f | Outreach/follow-up occurs after:

f. Medication refusal

Standard 5a–f

Figure A-15—ADHS Independent Case Review 2002: Standard 5a–f



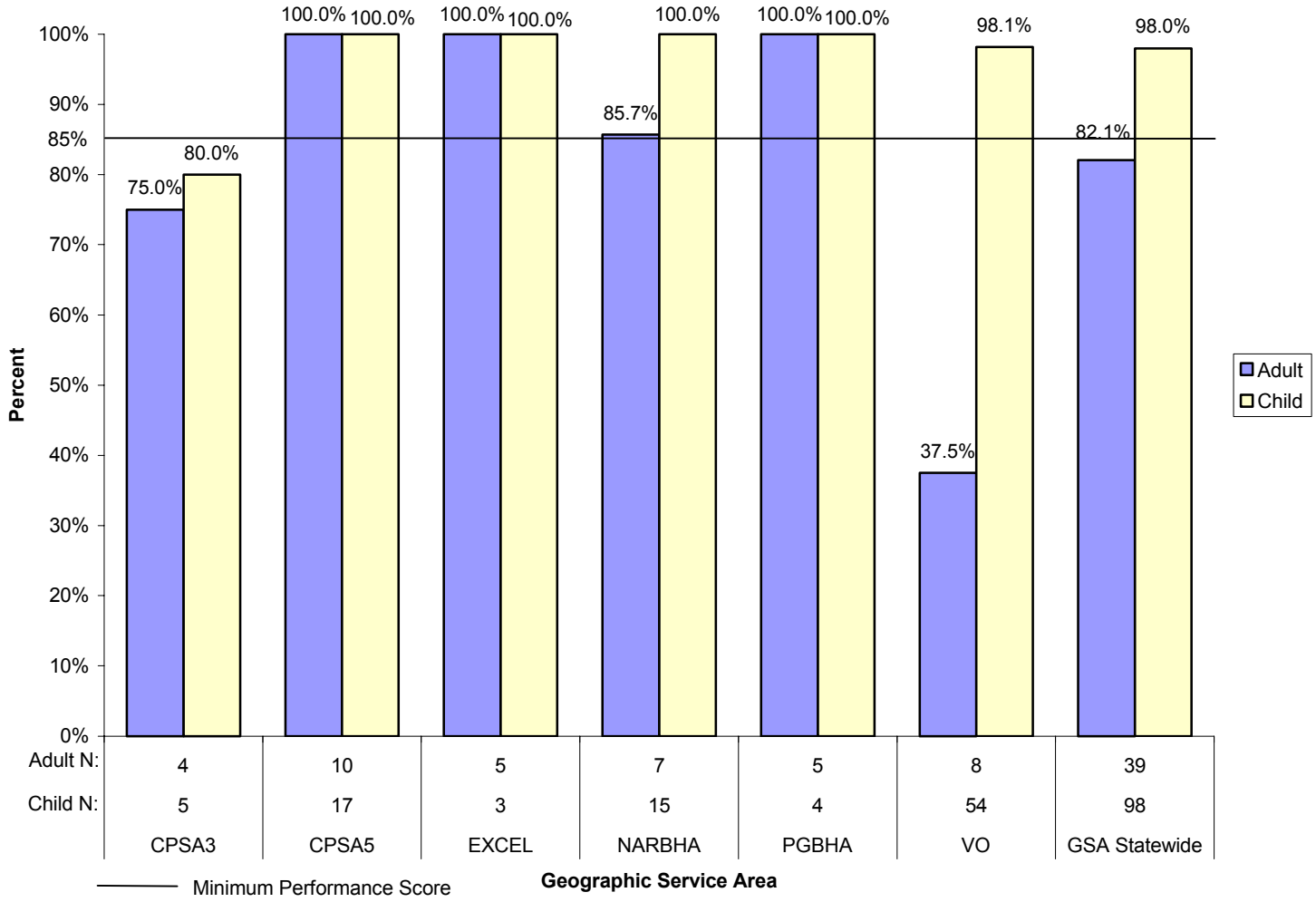
Standard 5a–f

Outreach/follow-up occurs after:

a. Discharge from inpatient
b. Discharge from residential
c. Missed appointments
d. Crisis episodes
e. Service refusal
f. Medication refusal

Standard 6 (For DDD Individuals Only)

Figure A-16—ADHS Independent Case Review 2002: Standard 6

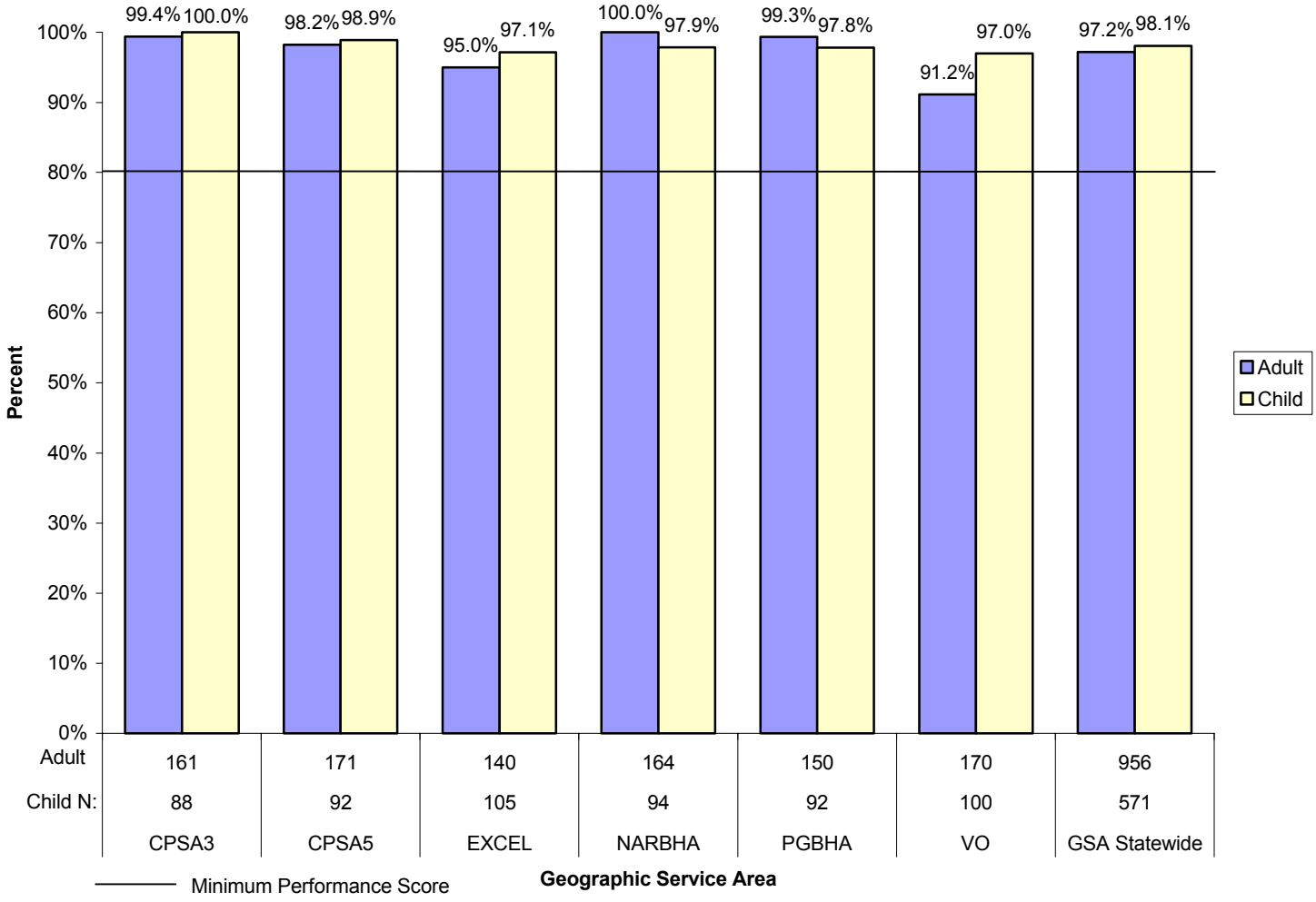


For DDD Individuals Only

Standard 6 Individuals with identified specialized service needs are referred for and receive these services.

Standard 7

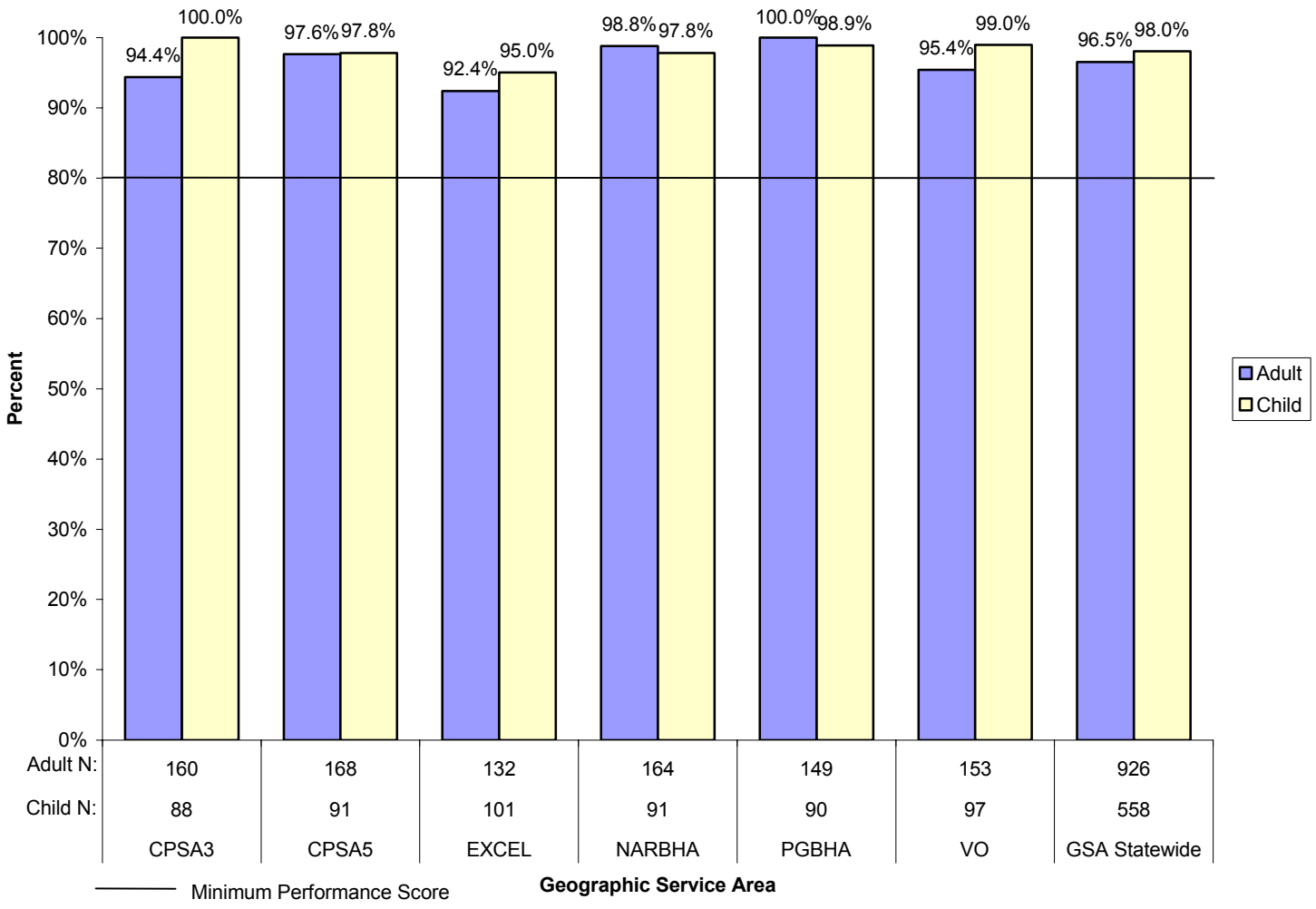
Figure A-17—ADHS Independent Case Review 2002: Standard 7



Standard 7 | The individual has an assigned clinician.

Standard 8

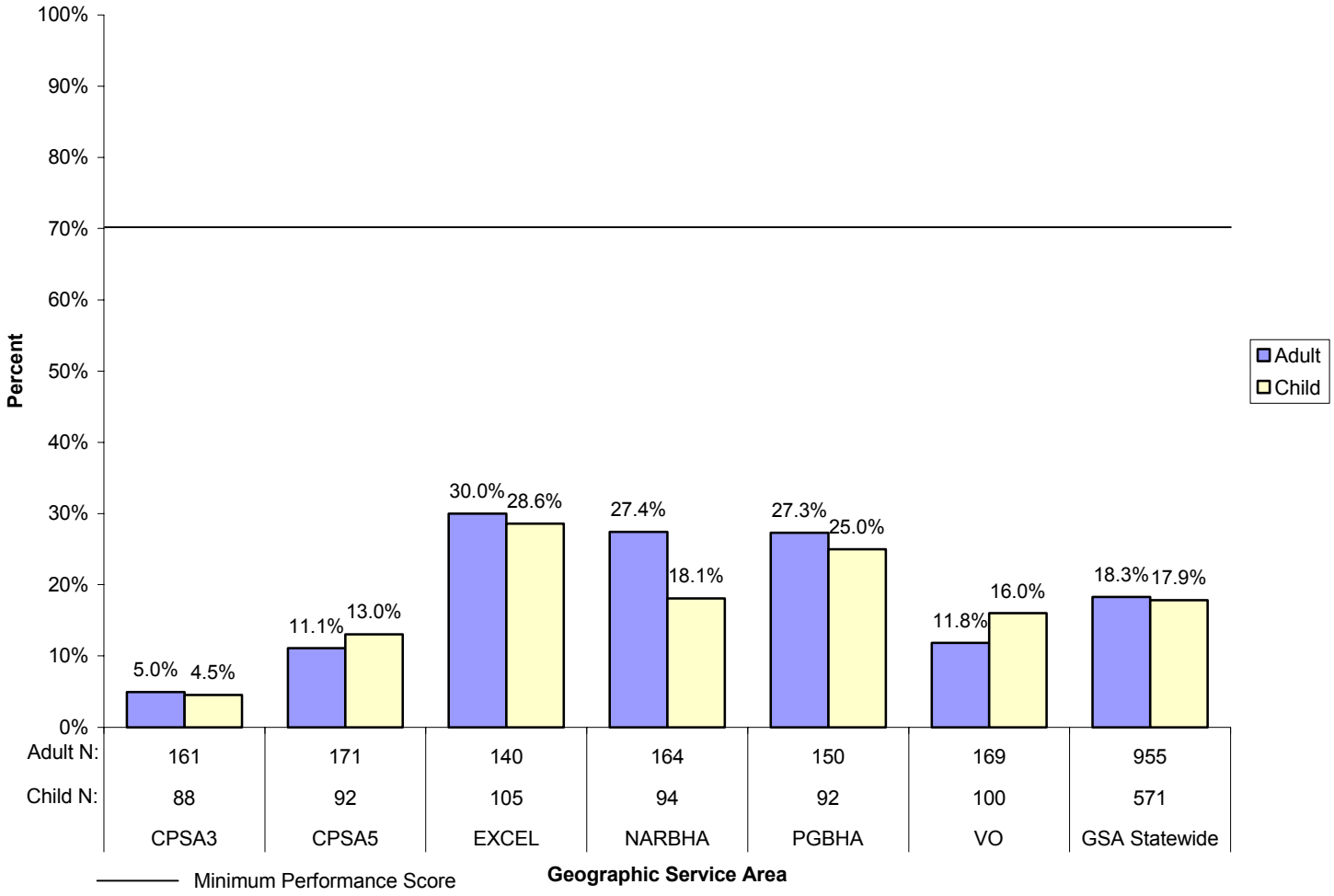
Figure A-18—ADHS Independent Case Review 2002: Standard 8



Standard 8 | The assigned clinician is actively involved in the oversight of the treatment.

Standard 9

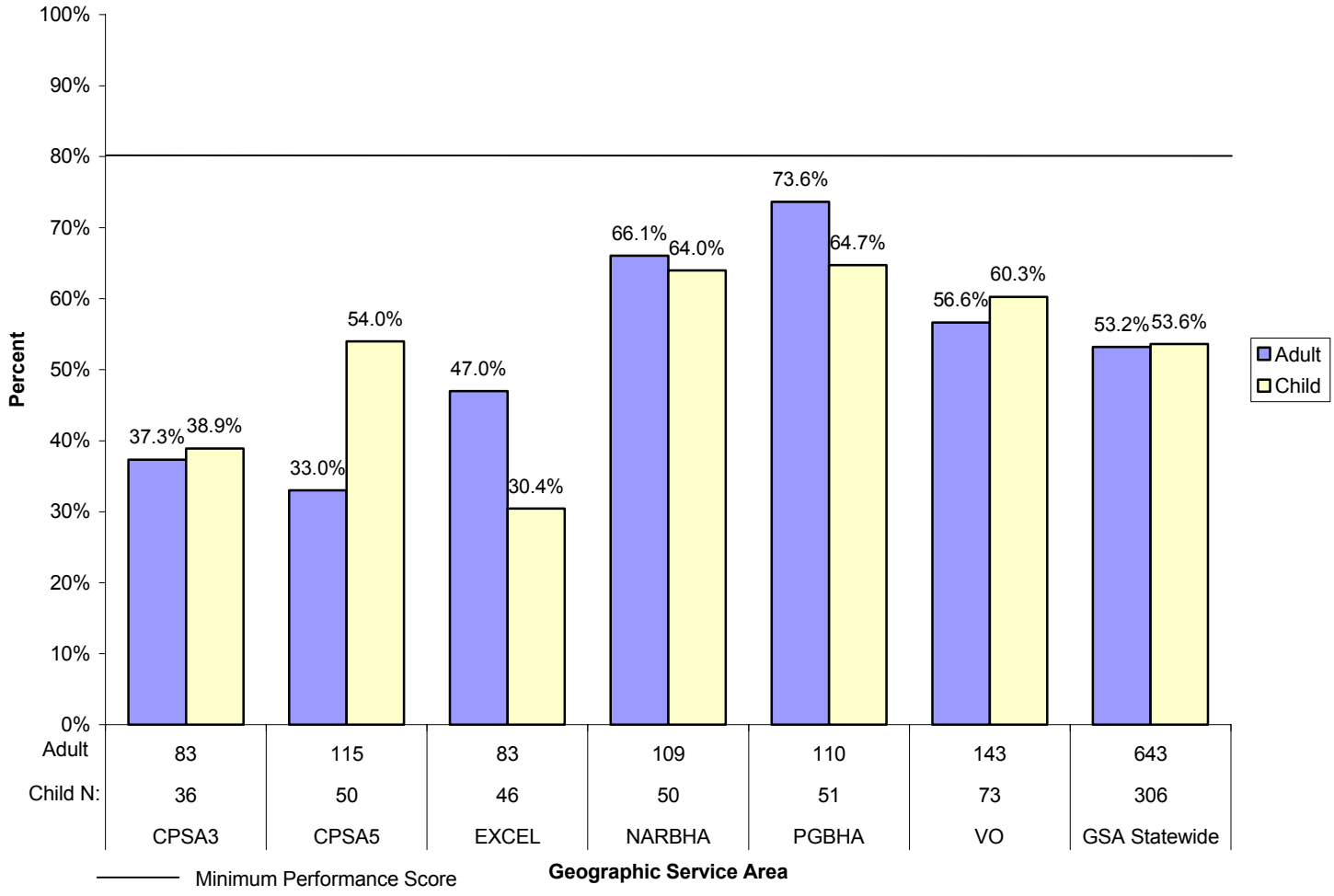
Figure A-19—ADHS Independent Case Review 2002: Standard 9



Standard 9	Individuals'/families' cultural preferences are assessed and included in the development of treatment plans.

Standard 10

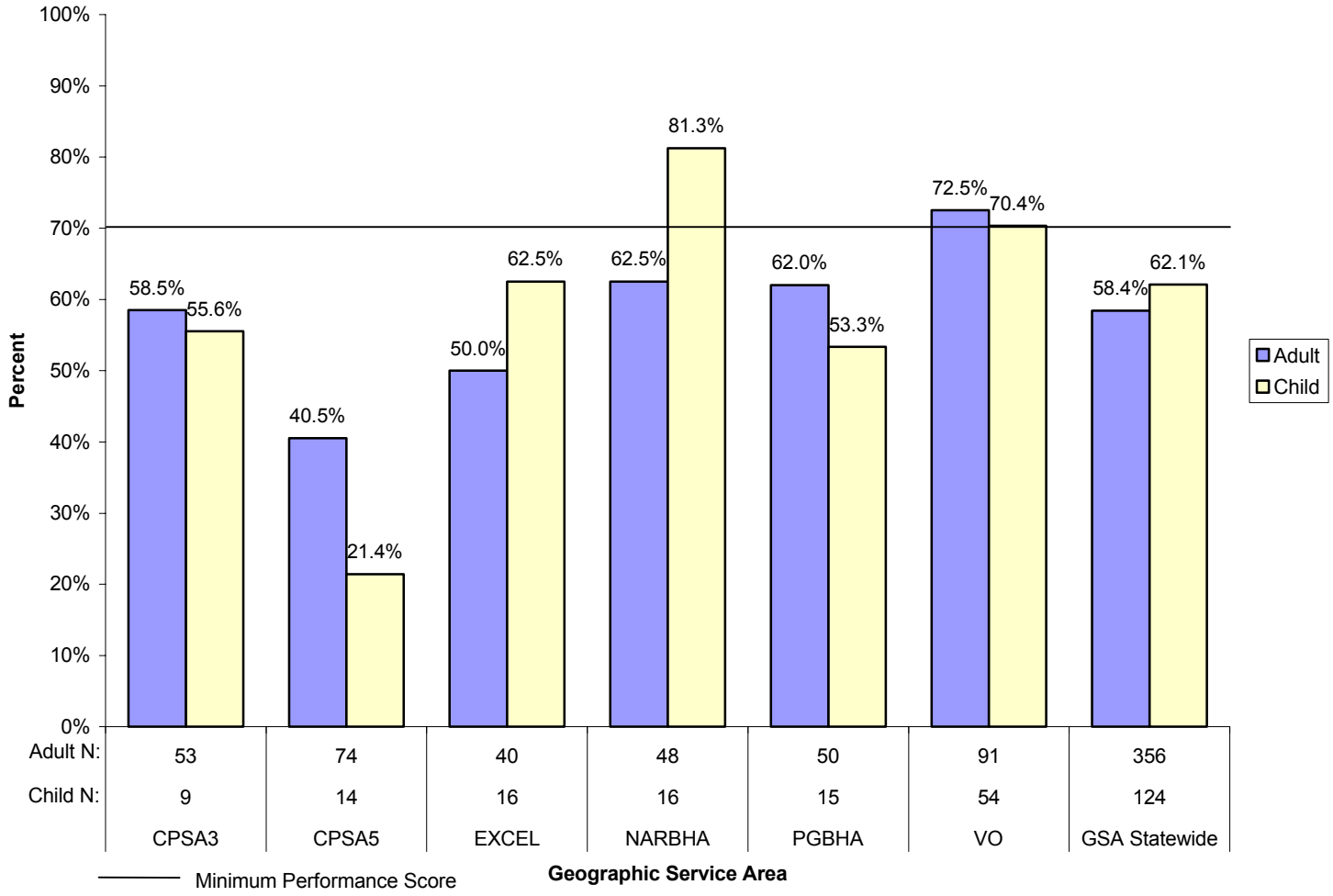
Figure A-20—ADHS Independent Case Review 2002: Standard 10



Standard 10 Individuals and/or parent/guardians are informed about and give consent for prescribed medications.

Standard 11

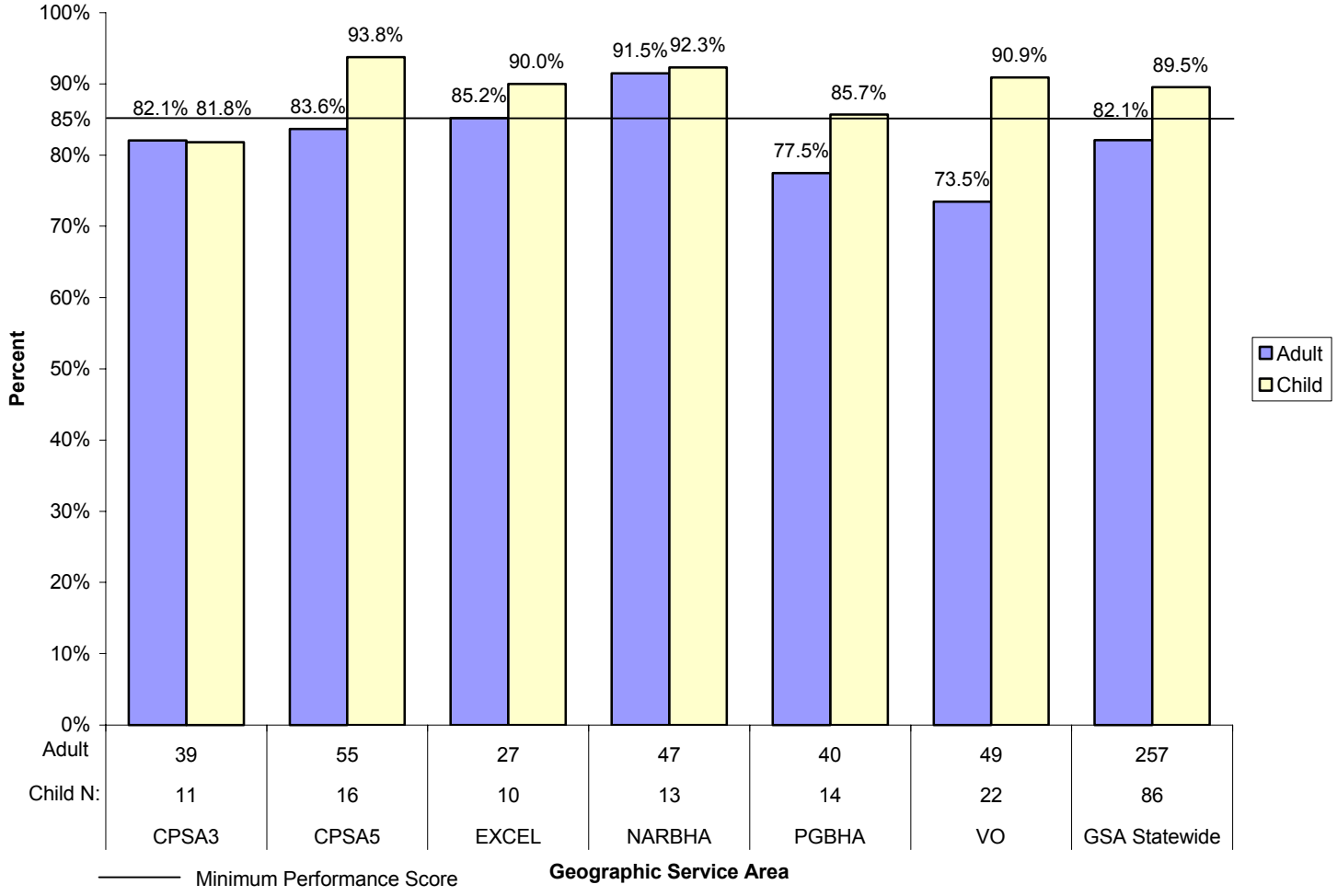
Figure A-21—ADHS Independent Case Review 2002: Standard 11



Standard 11 If the individual has been prescribed anti-psychotic medication, regular assessments for movement disorders are documented.

Standard 12

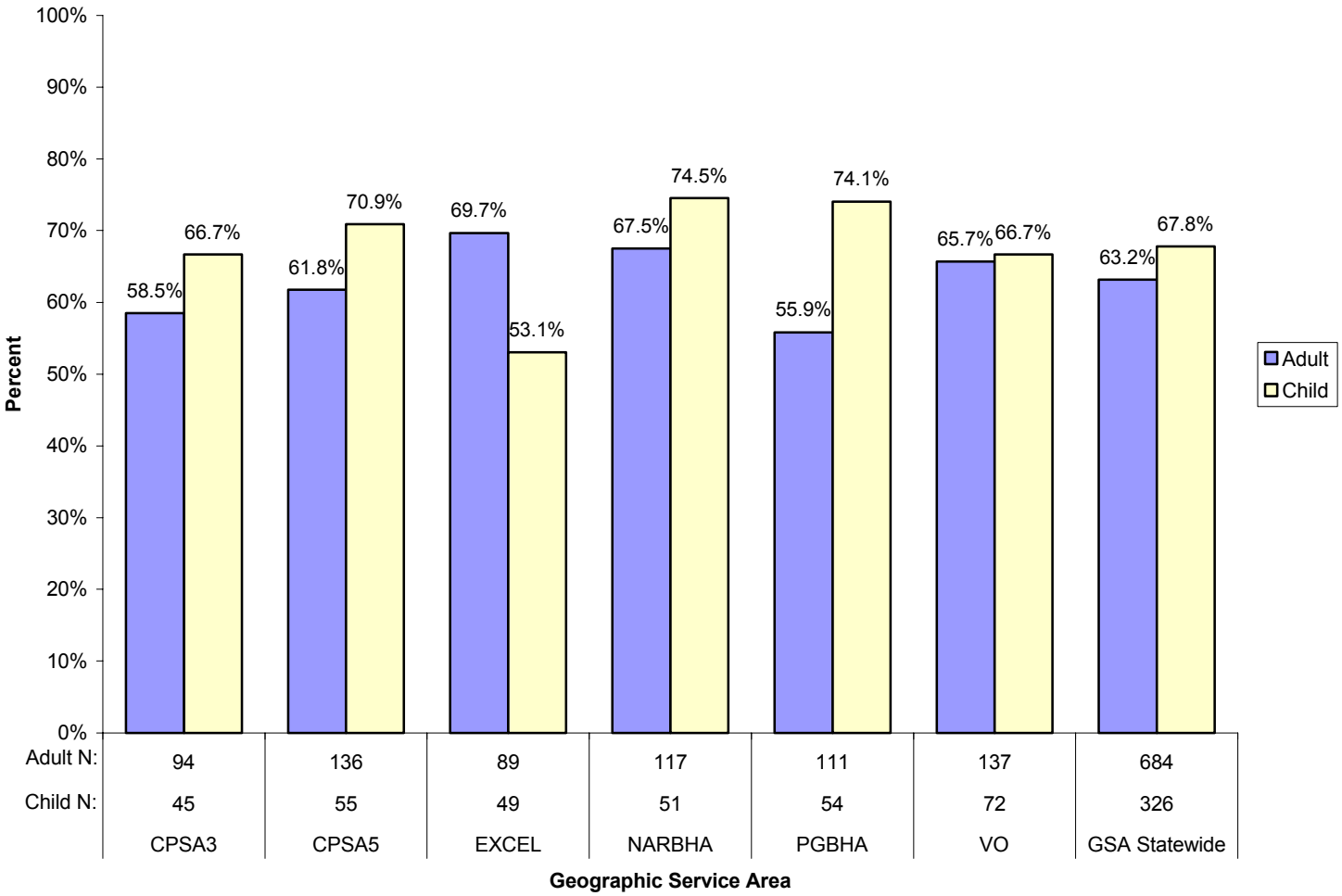
Figure A-22—ADHS Independent Case Review 2002: Standard 12



Standard 12 If the individual has been prescribed psychotropic medications and adverse reactions or side effects are noted, progress notes include documentation of follow-up actions to address adverse effects.

Standard 13

Figure A-23—ADHS Independent Case Review 2002: Standard 13

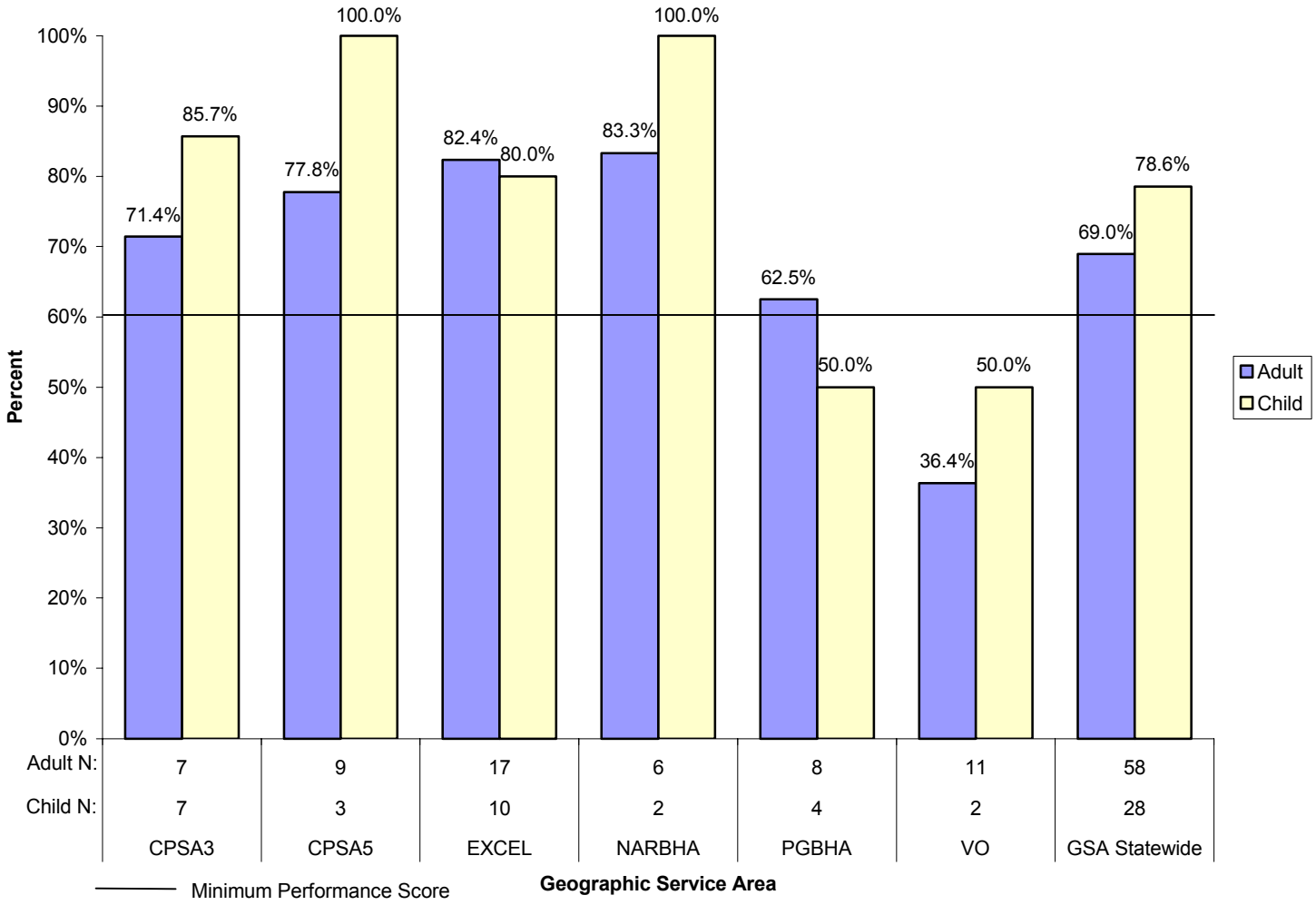


Note: A Minimum Performance Score has not been established for this standard.

Standard 13	If the individual has been prescribed psychotropic medication, the record includes documentation of specific target symptoms.

Standard 14

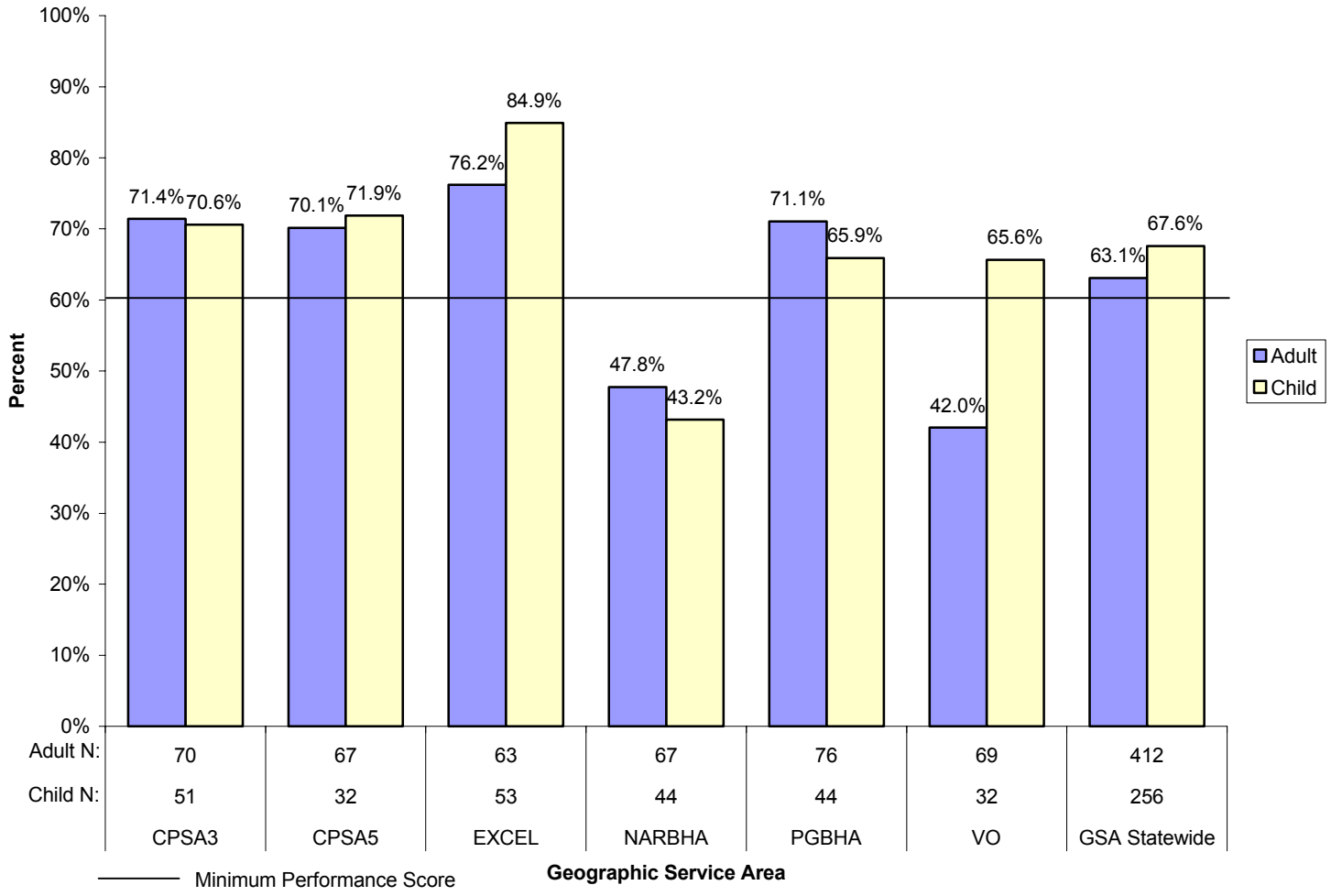
Figure A-24—ADHS Independent Case Review 2002: Standard 14



Standard 14 The disposition of the referral from the PCP or Health Plan is communicated to the PCP or Health Plan within 30 days of receiving the request for service.

Standard 15a

Figure A-25—ADHS Independent Case Review 2002: Standard 15a

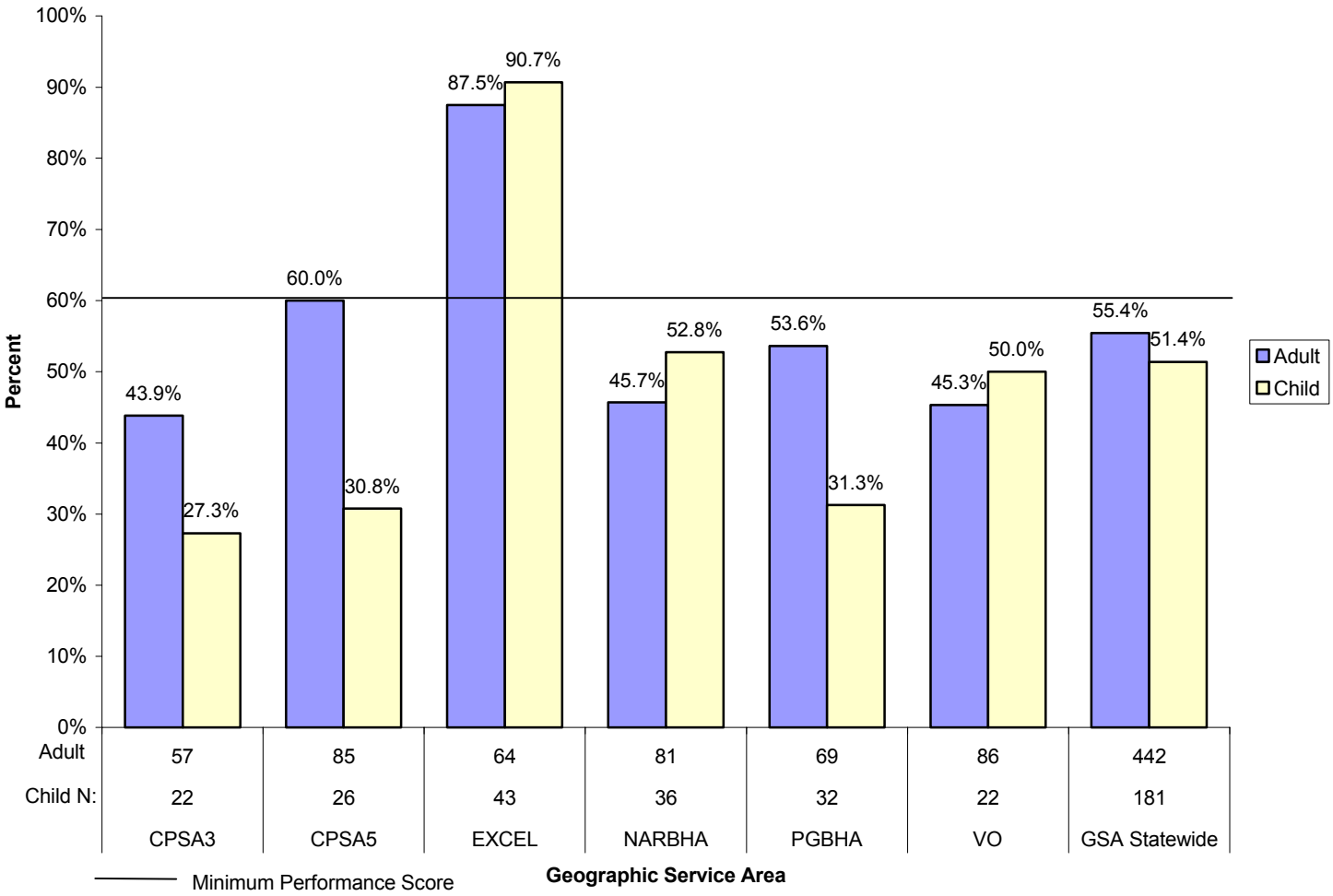


Standard 15a Behavioral health care has been communicated or attempts have been made to coordinate with the PCP in the following circumstances:

a. Initial assessment and treatment recommendations

Standard 15b

Figure A-26—ADHS Independent Case Review 2002: Standard 15b



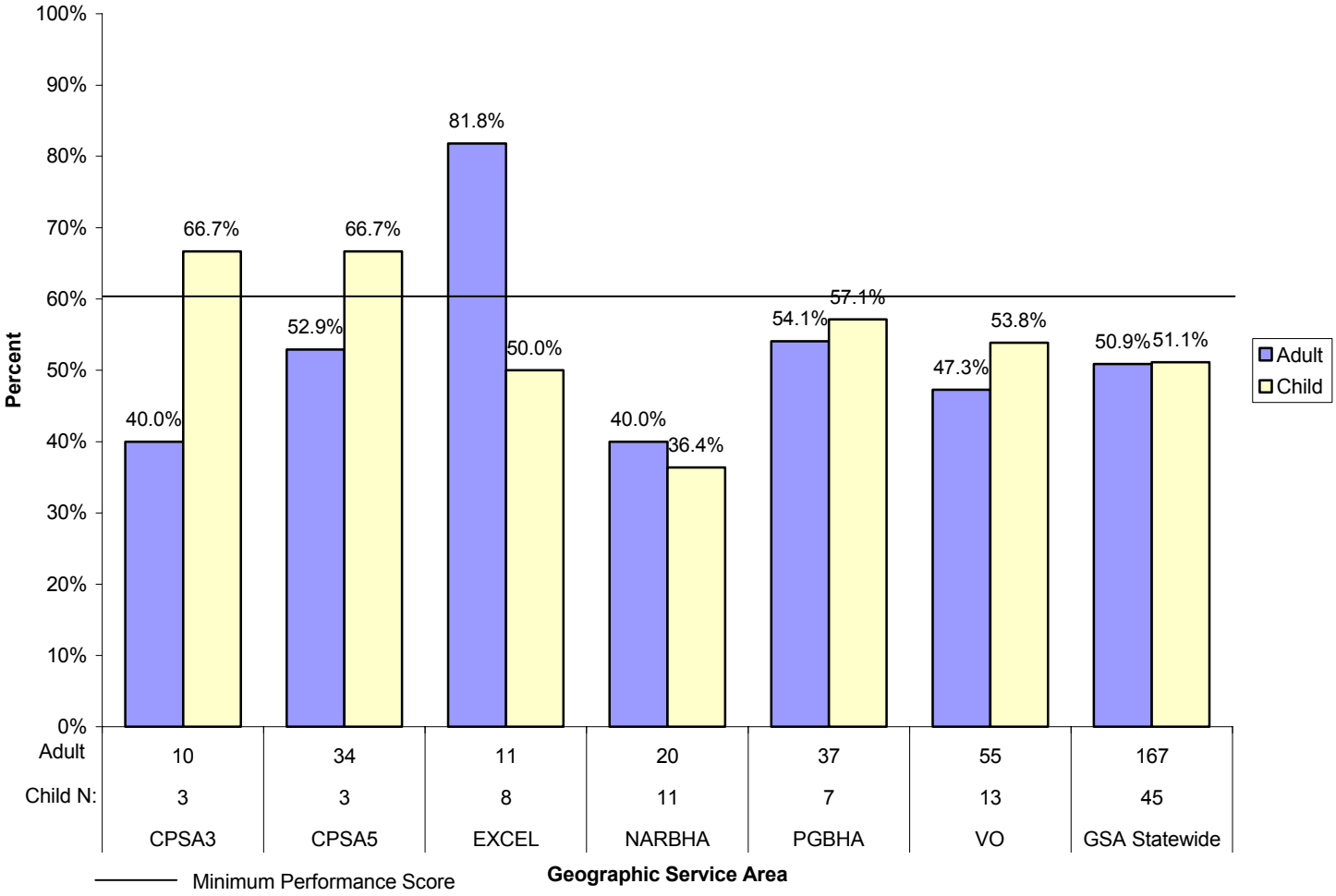
Standard 15b

Behavioral health care has been communicated or attempts have been made to coordinate with the PCP in the following circumstances:

b. Initiation and significant changes in psychotropic medications and significant adverse reactions

Standard 15c

Figure A-27—ADHS Independent Case Review 2002: Standard 15c

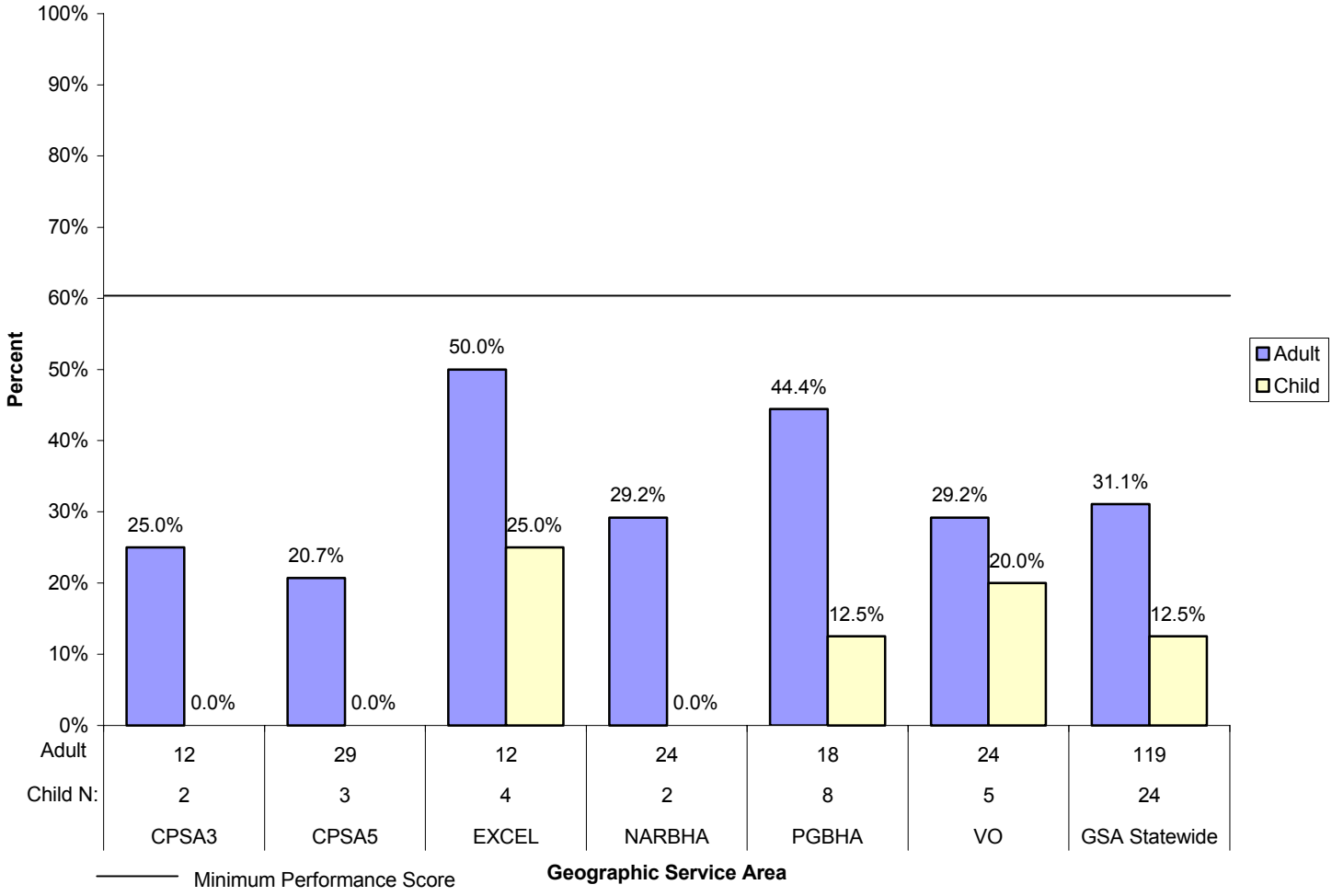


Standard 15c Behavioral health care has been communicated or attempts have been made to coordinate with the PCP in the following circumstances:

c. Results of relevant laboratory, radiology, and other tests

Standard 15d

Figure A-28—ADHS Independent Case Review 2002: Standard 15d



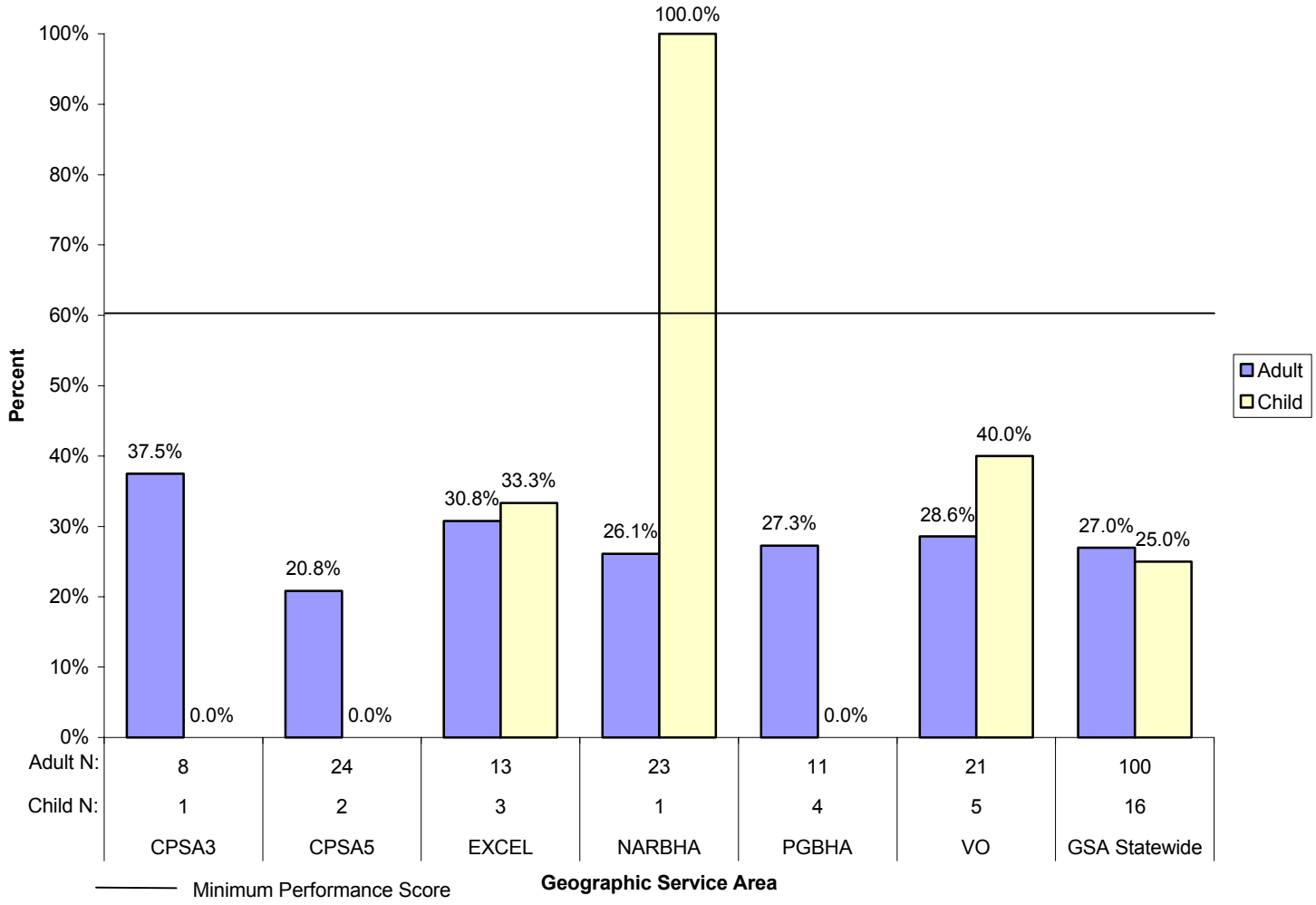
Standard 15d

Behavioral health care has been communicated or attempts have been made to coordinate with the PCP in the following circumstances:

d. Emergency/crisis admission or events

Standard 15e

Figure A-29—ADHS Independent Case Review 2002: Standard 15e

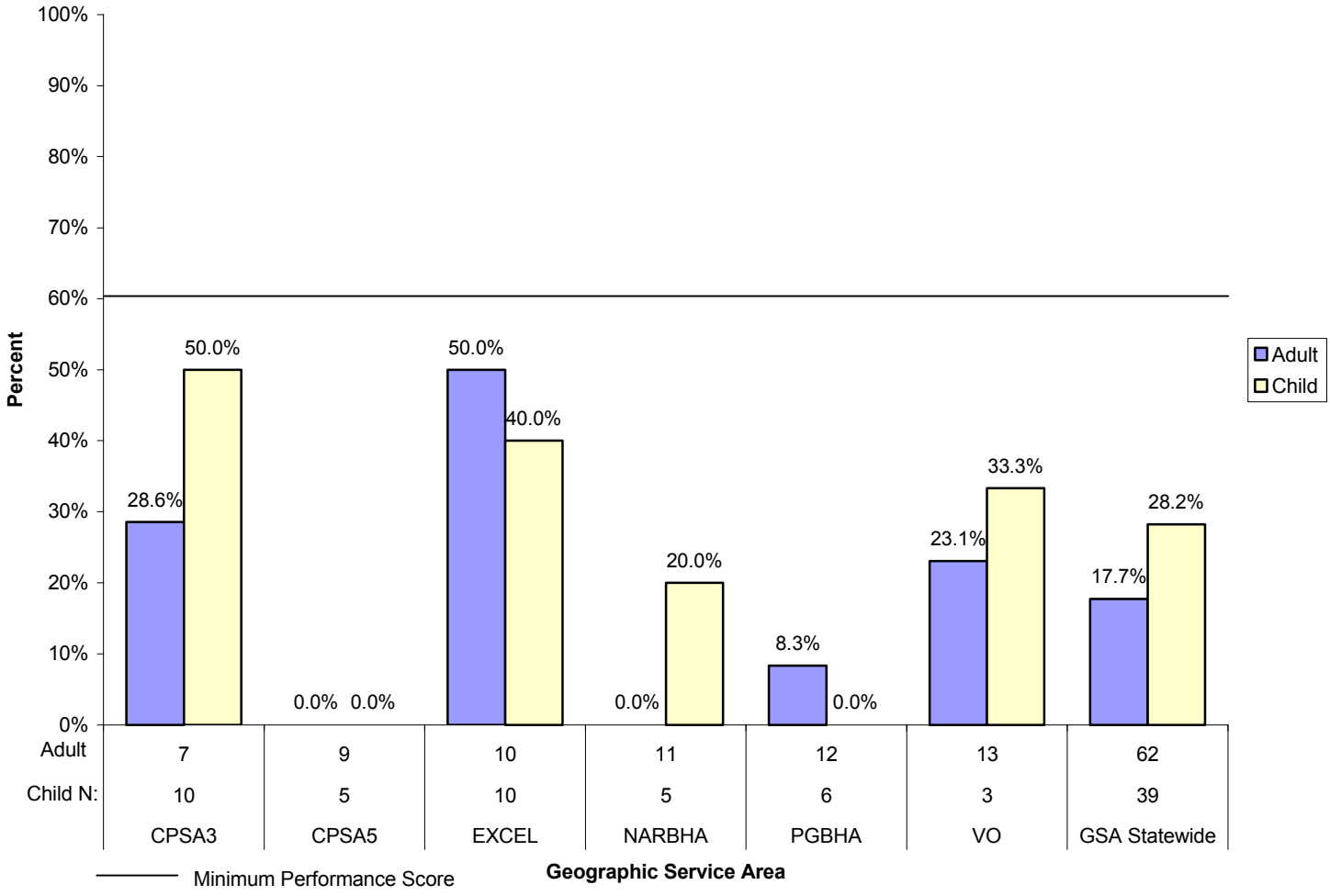


Standard 15e Behavioral health care has been communicated or attempts have been made to coordinate with the PCP in the following circumstances:

e. Discharge from an inpatient setting

Standard 15f

Figure A-30—ADHS Independent Case Review 2002: Standard 15f

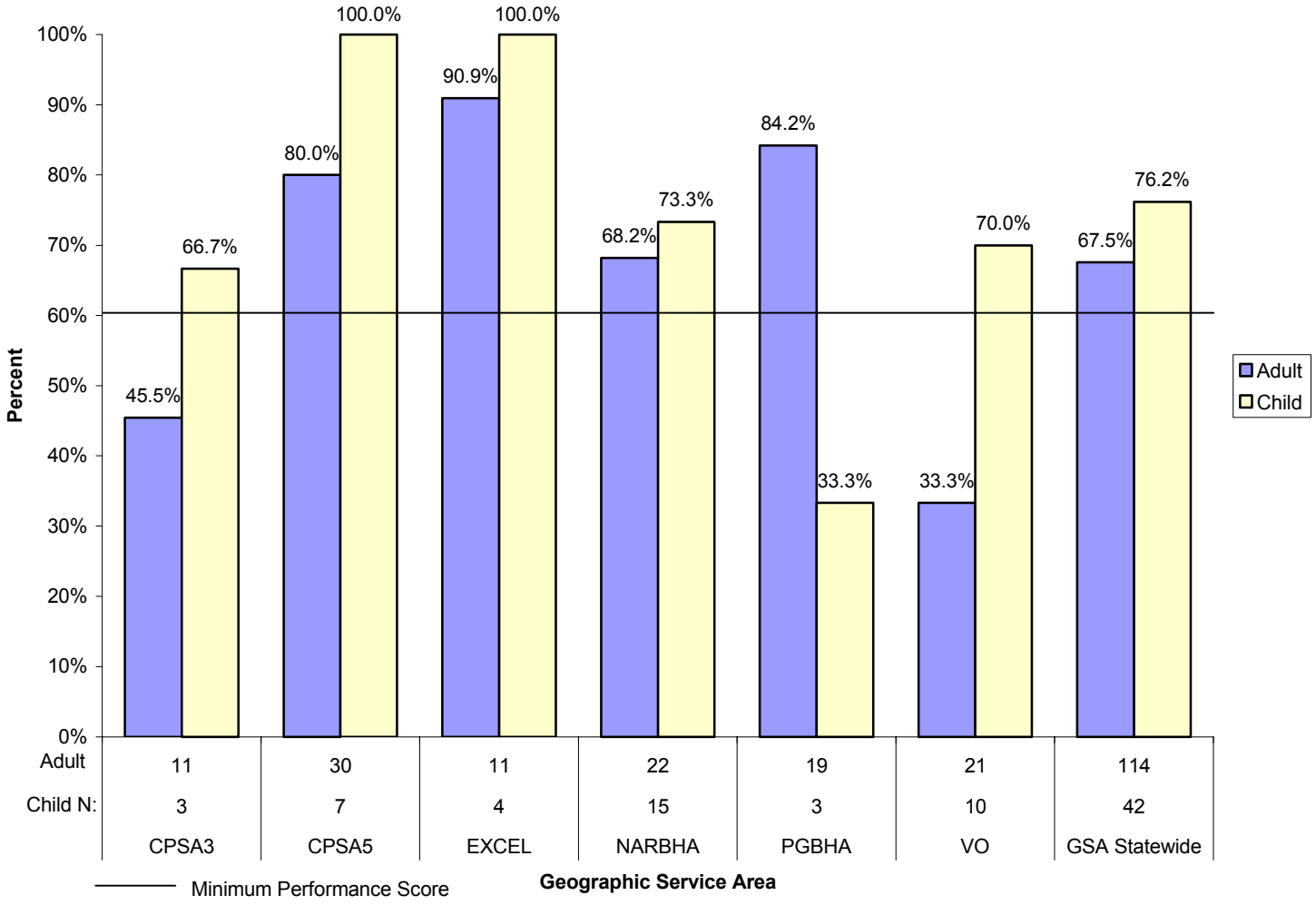


Standard 15f Behavioral health care has been communicated or attempts have been made to coordinate with the PCP in the following circumstances:

f. Disenrollment from ADHS/RBHA

Standard 15g

Figure A-31—ADHS Independent Case Review 2002: Standard 15g



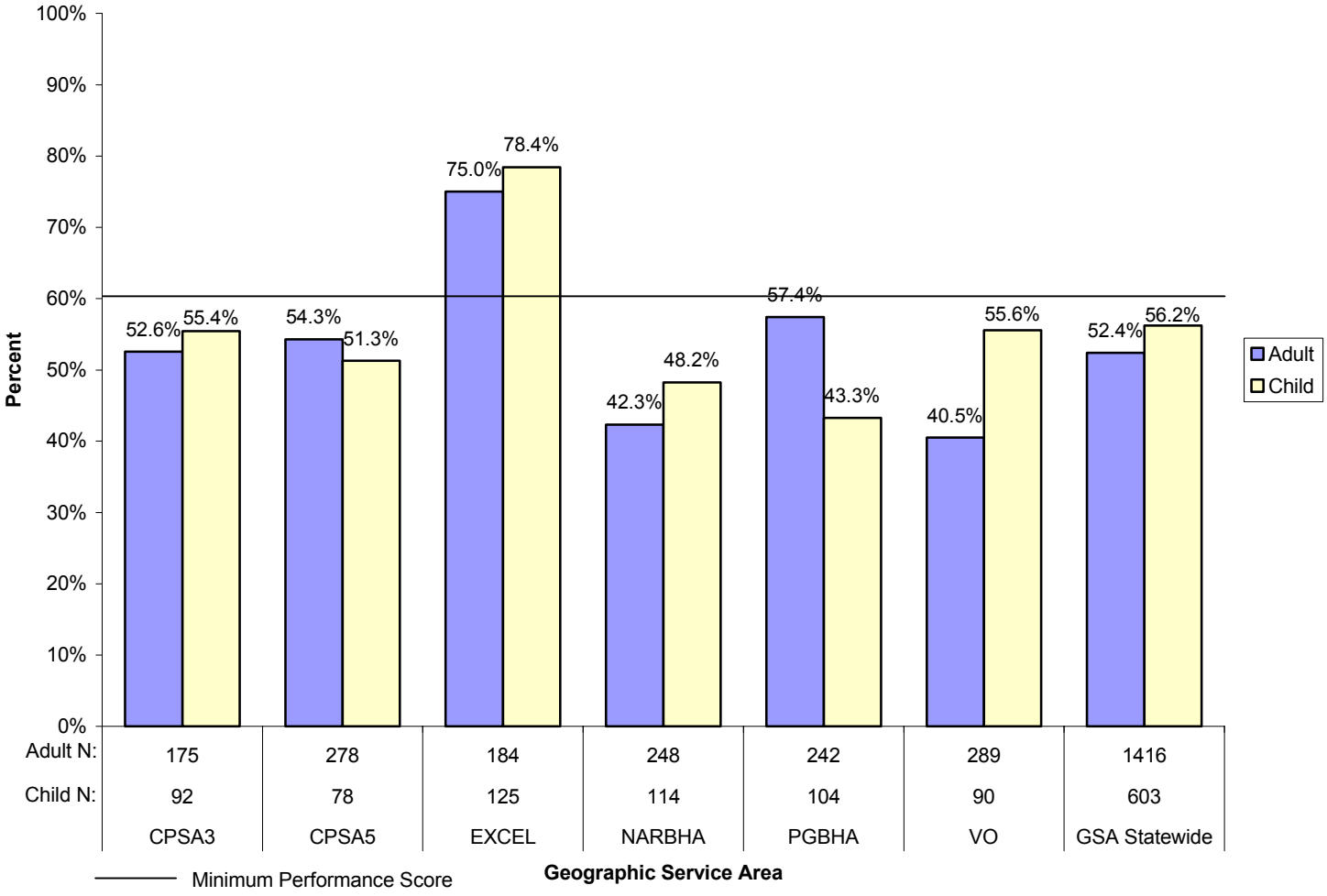
Standard 15g

Behavioral health care has been communicated or attempts have been made to coordinate with the PCP in the following circumstances:

g. Any other events requiring medical consultation with the individual's PCP

Standard 15a–g

Figure A-32—ADHS Independent Case Review 2002: Standard 15a–g



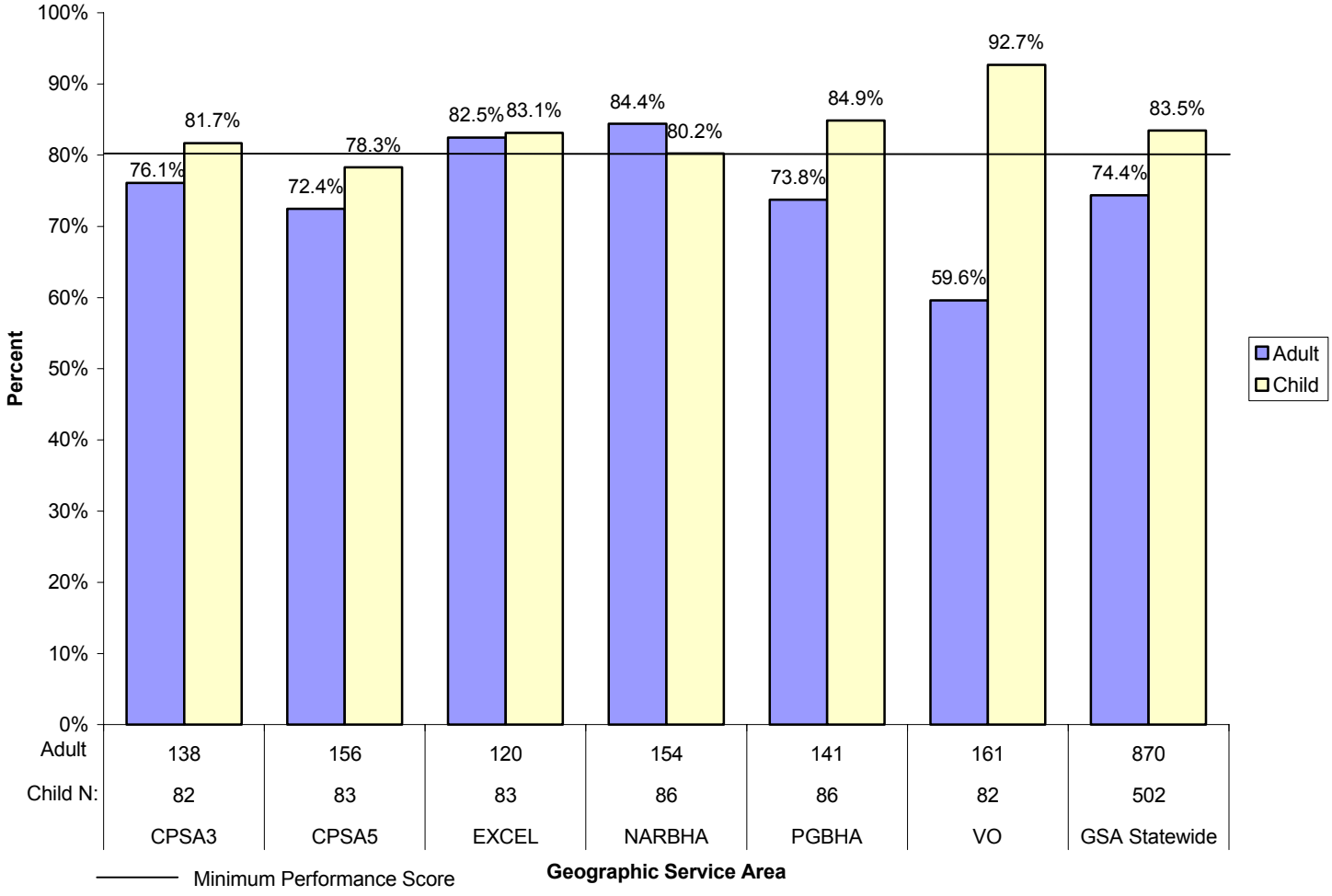
Standard 15a–g

Behavioral health care has been communicated or attempts have been made to coordinate with the PCP in the following circumstances:

a. Initial assessment and treatment recommendations
b. Initiation and significant changes in psychotropic medications and significant adverse reactions
c. Results of relevant laboratory, radiology, and other tests
d. Emergency/crisis admission or events
e. Discharge from an inpatient setting
f. Disenrollment from ADHS/RBHA
g. Any other events requiring medical consultation with the individual's PCP

Standard 16

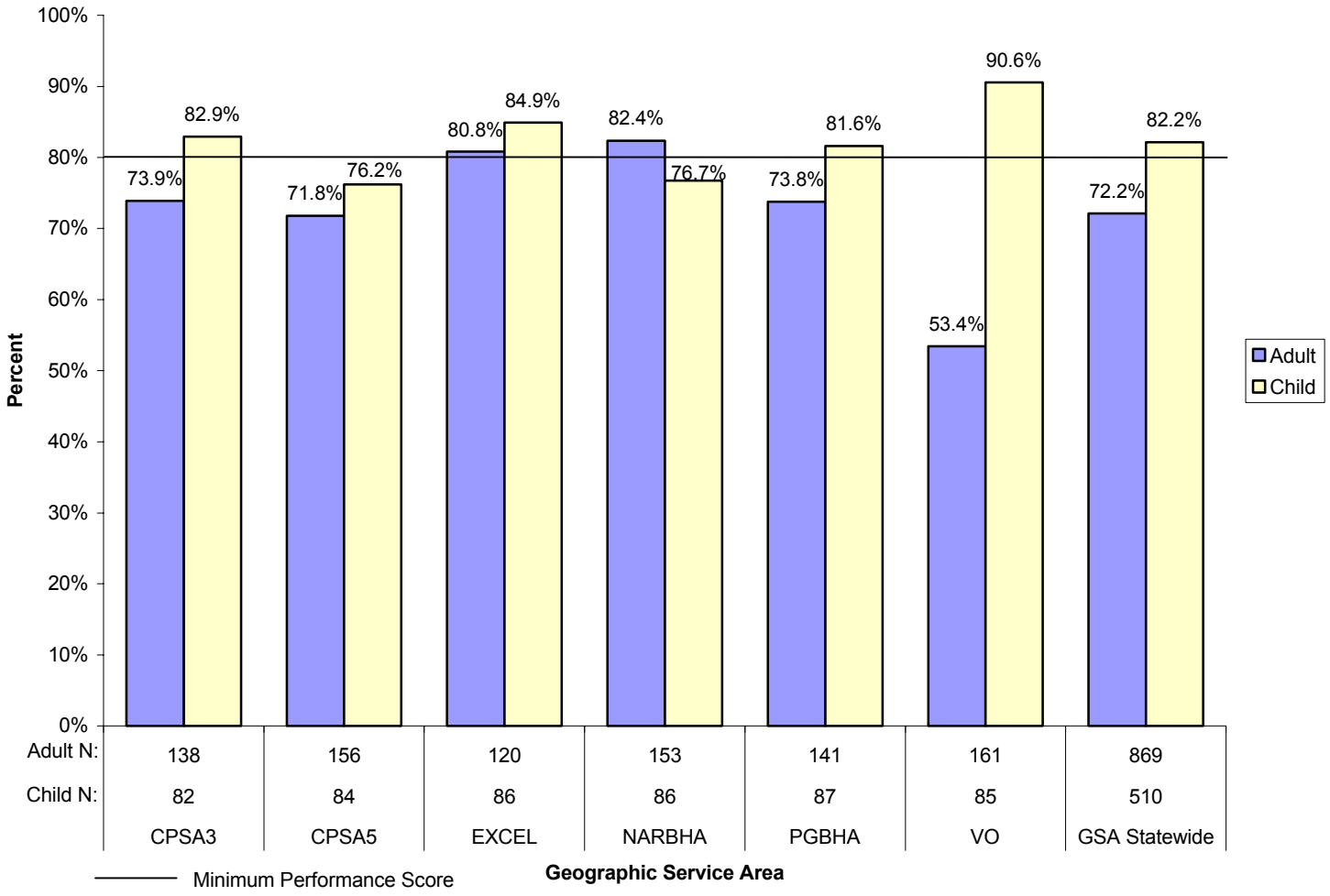
Figure A-33—ADHS Independent Case Review 2002: Standard 16



Standard 16 | There is evidence of symptomatic improvement.

Standard 17

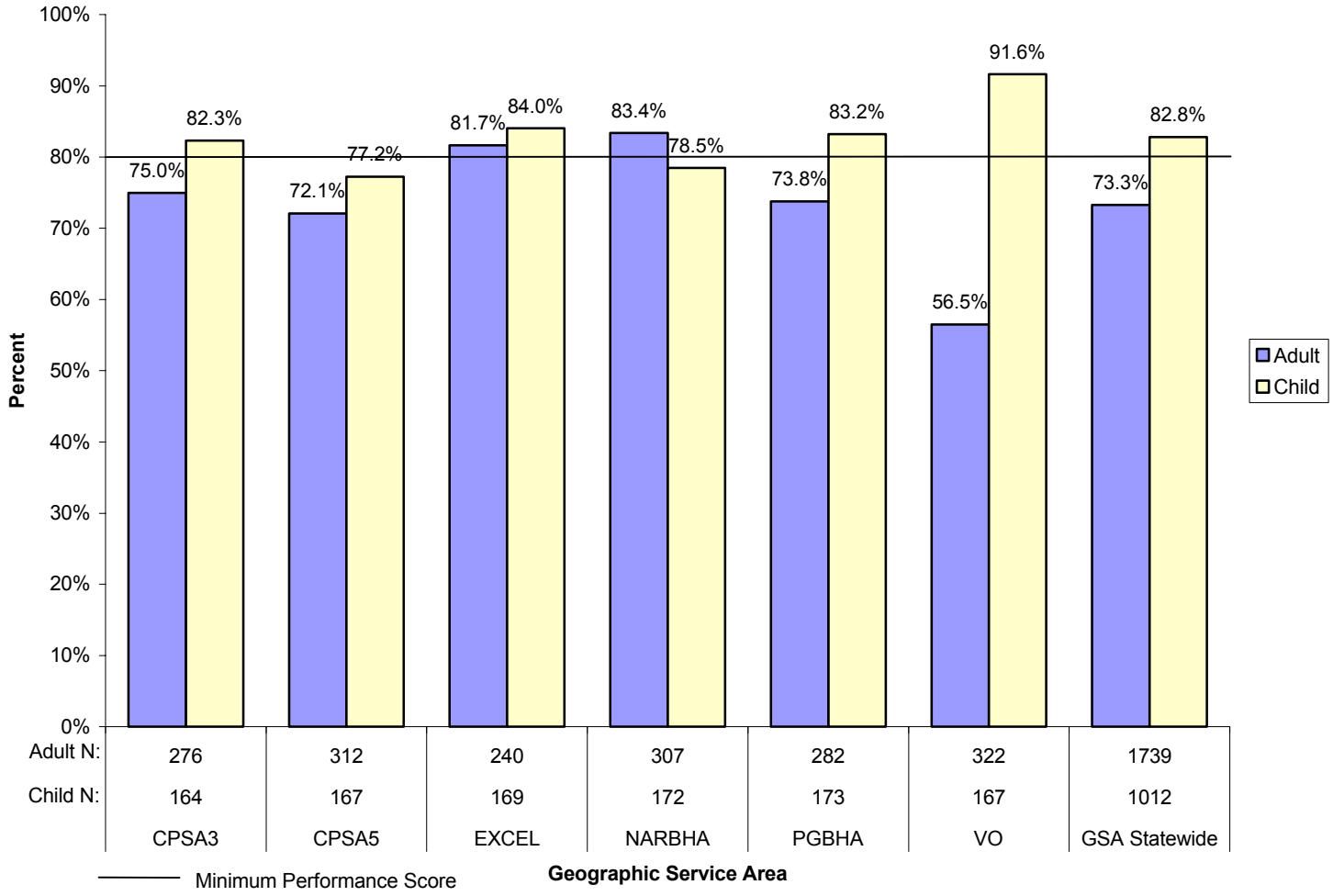
Figure A-34—ADHS Independent Case Review 2002: Standard 17



Standard 17 | There is evidence of functional improvement.

Standards 16 and 17

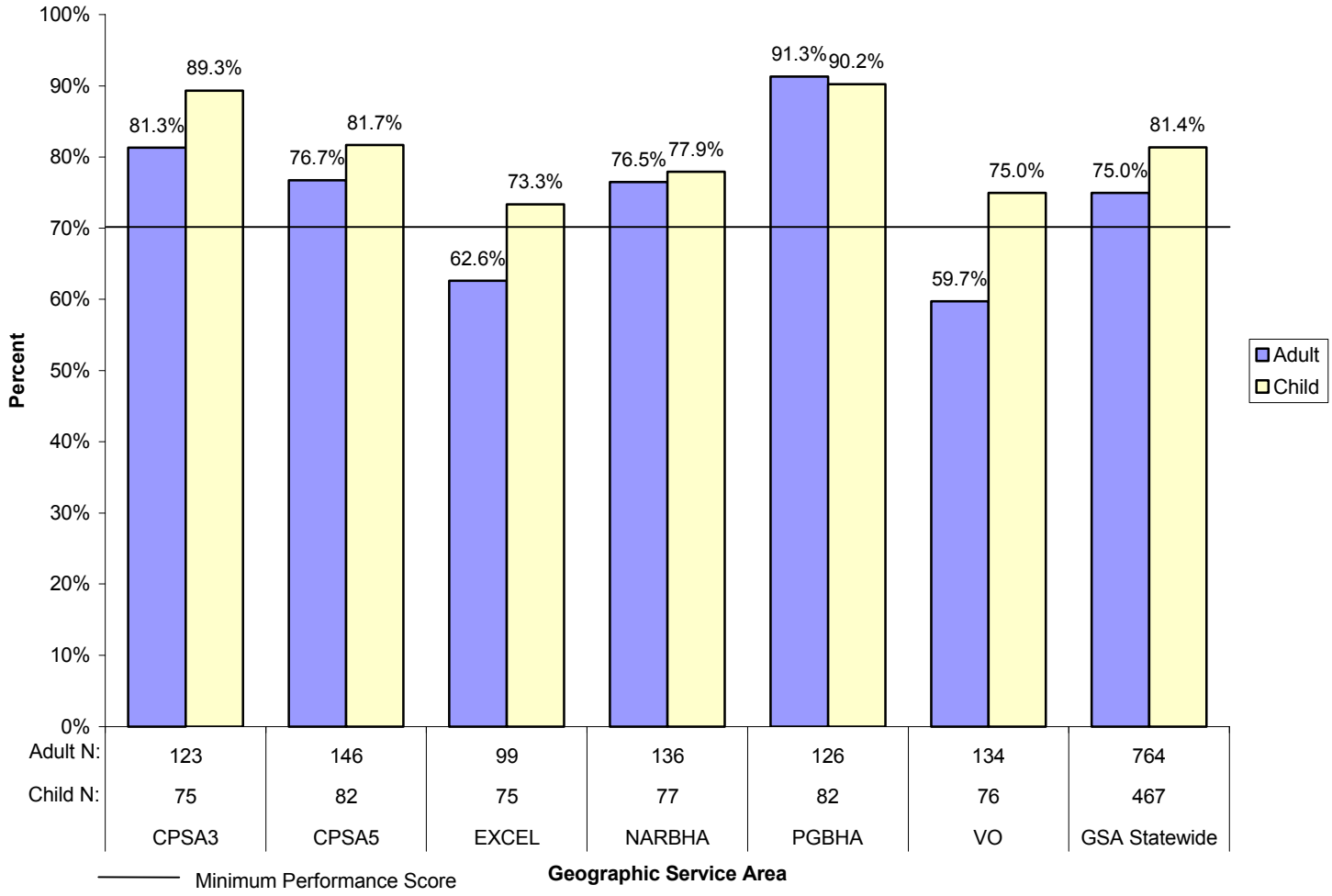
Figure A-35—ADHS Independent Case Review 2002: Standards 16 and 17



Standards 16 & 17 | This chart is the roll-up of Standards 16 and 17.

Standard 18

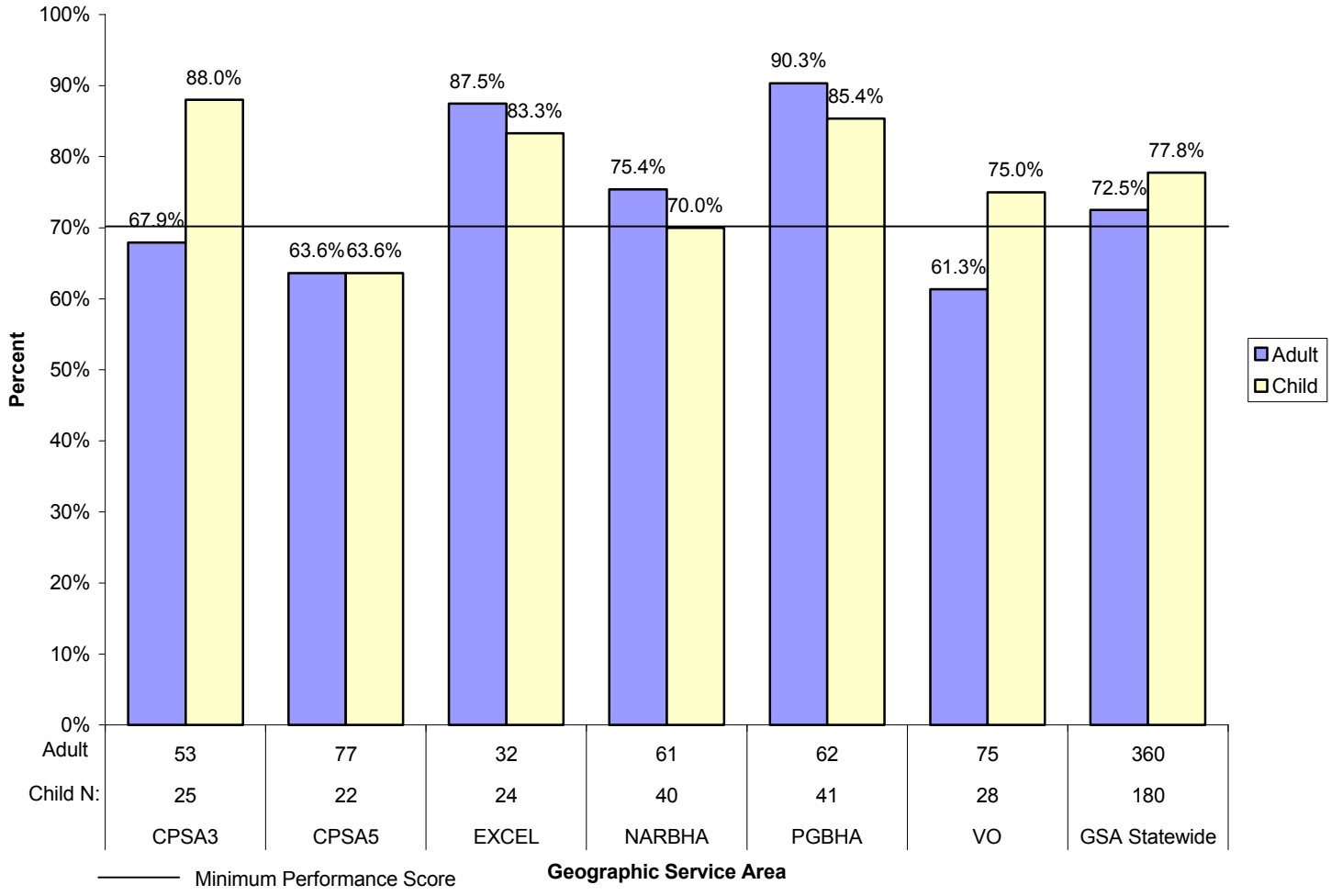
Figure A-36—ADHS Independent Case Review 2002: Standard 18



Standard 18 Service plans and/or services are revised based on progress or lack of progress in the individual's behavioral health condition.

Standard 19

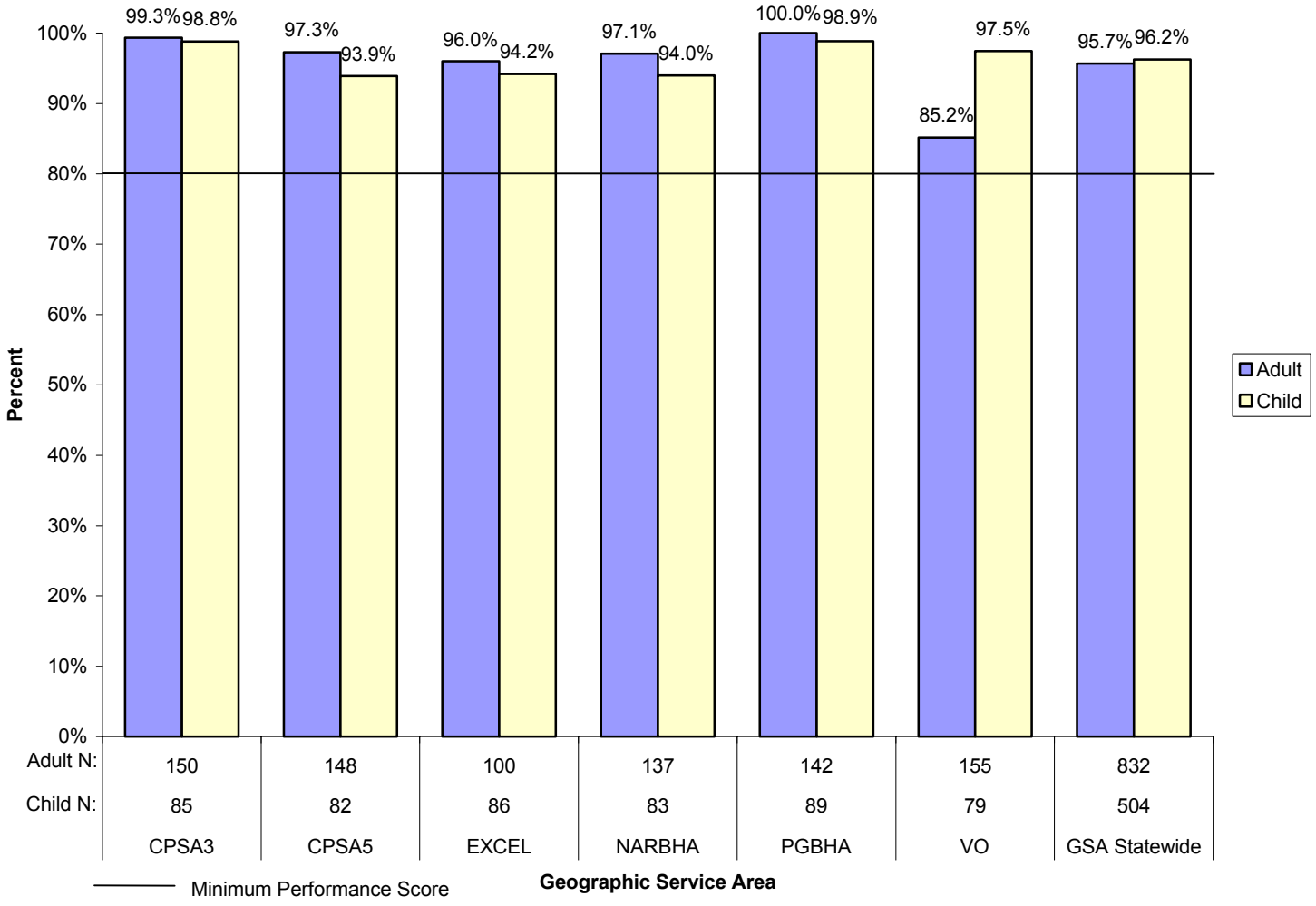
Figure A-37—ADHS Independent Case Review 2002: Standard 19



Standard 19 Service plans and/or services are revised based on significant changes in the individual's behavioral health condition.

Standard 20a

Figure A-38—ADHS Independent Case Review 2002: Standard 20a

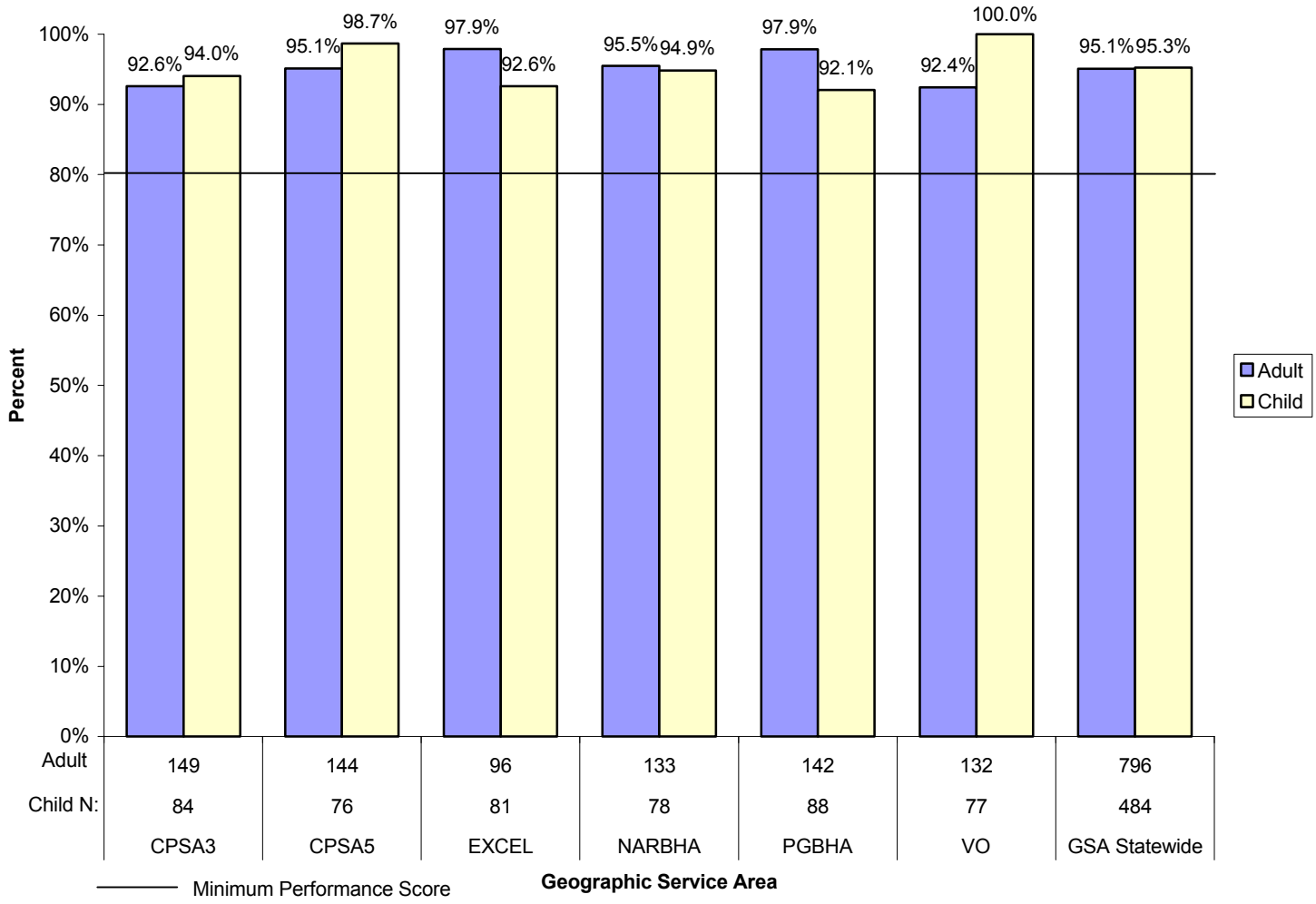


Standard 20a The treatment plan:

a. Incorporates the identified needs of the individual

Standard 20b

Figure A-39—ADHS Independent Case Review 2002: Standard 20b

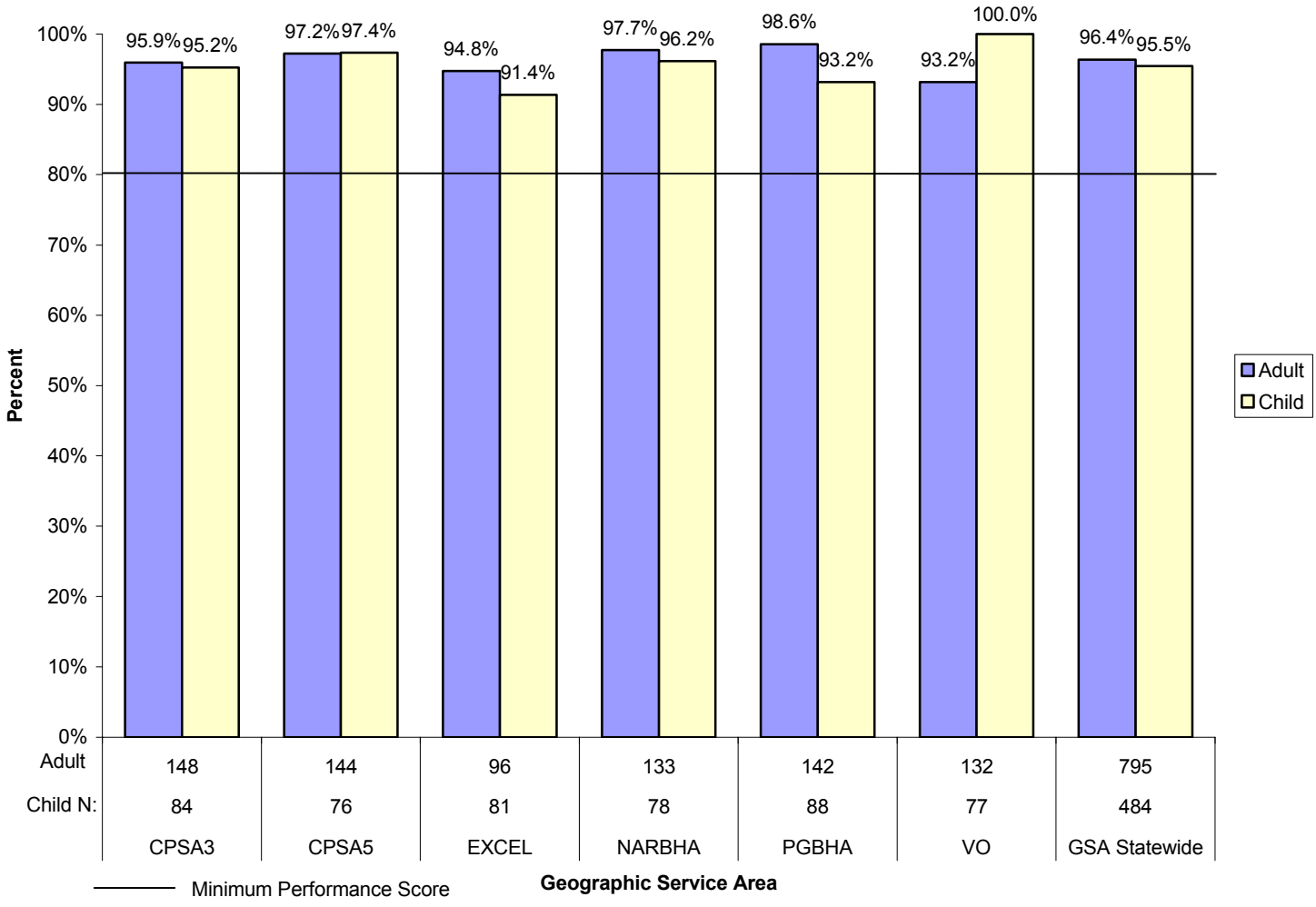


Standard 20b The treatment plan:

b. Includes measurable goals which address those needs

Standard 20c

Figure A-40—ADHS Independent Case Review 2002: Standard 20c

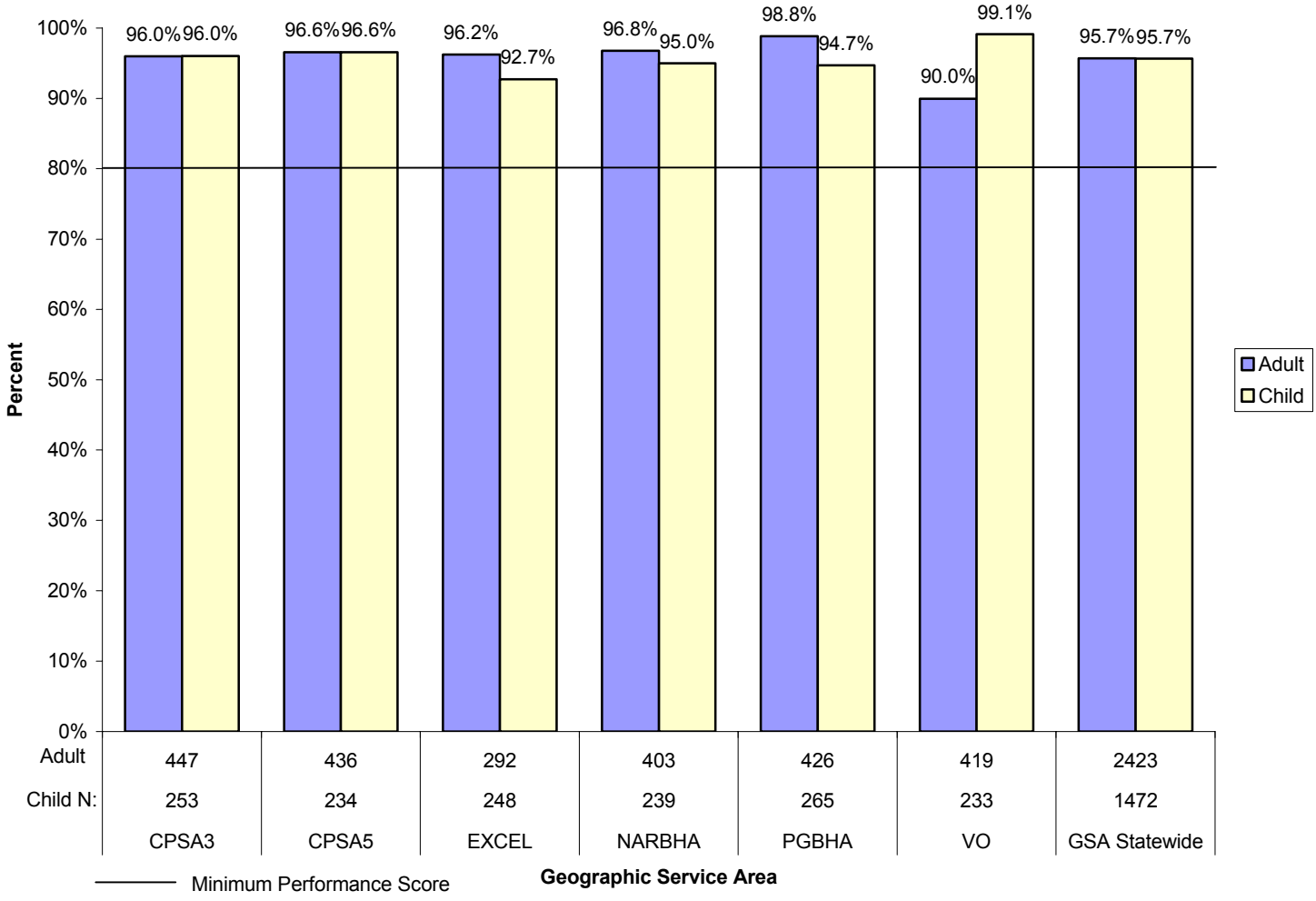


Standard 20c The treatment plan:

c. Describes specific action steps to reasonably accomplish the goals

Standard 20a–c

Figure A-41—ADHS Independent Case Review 2002: Standard 20a–c



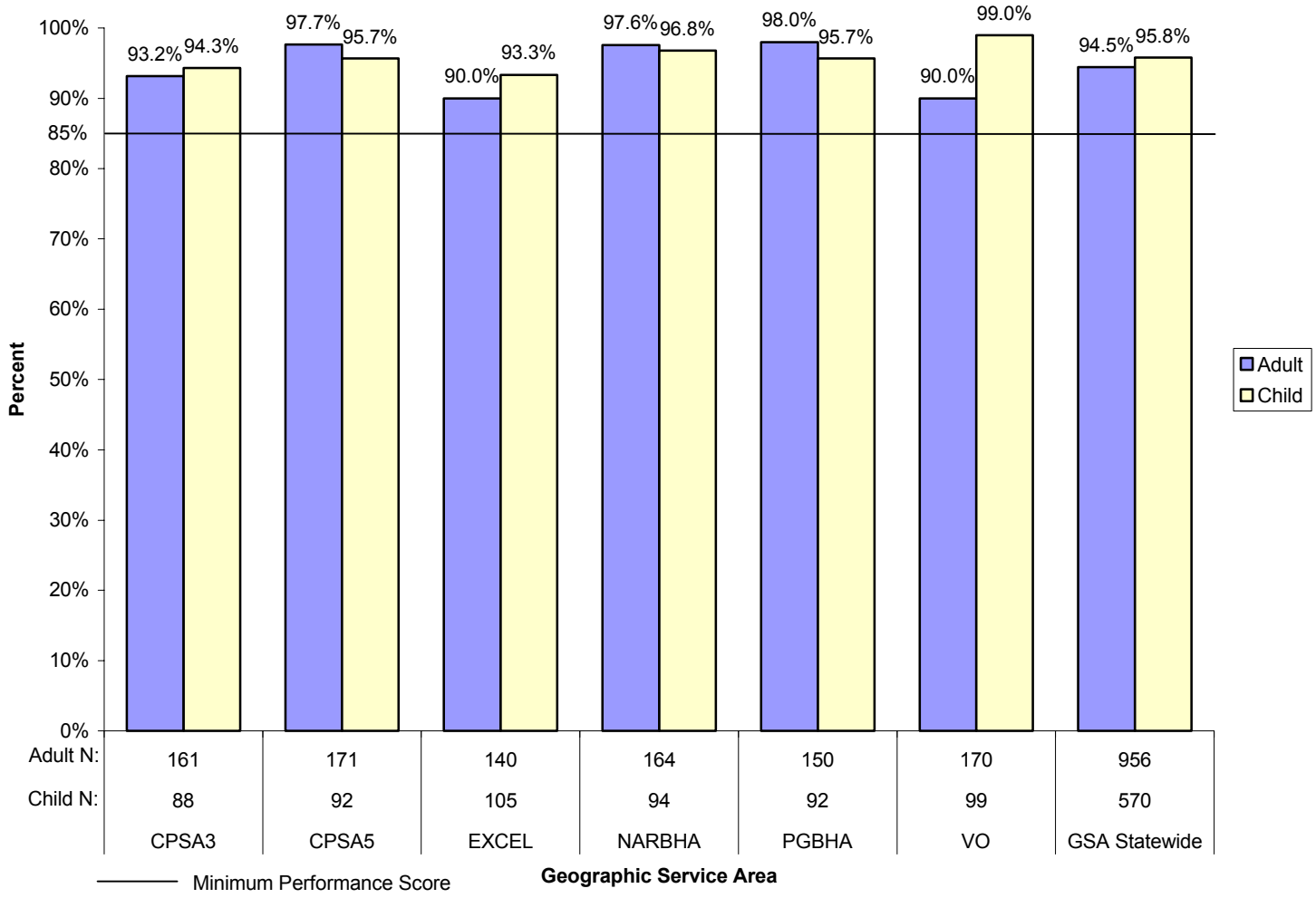
Standard 20a–c

The treatment plan:

a. Incorporates the identified needs of the individual
b. Includes measurable goals which address those needs
c. Describes specific action steps to reasonably accomplish the goals

Standard 21

Figure A-42—ADHS Independent Case Review 2002: Standard 21



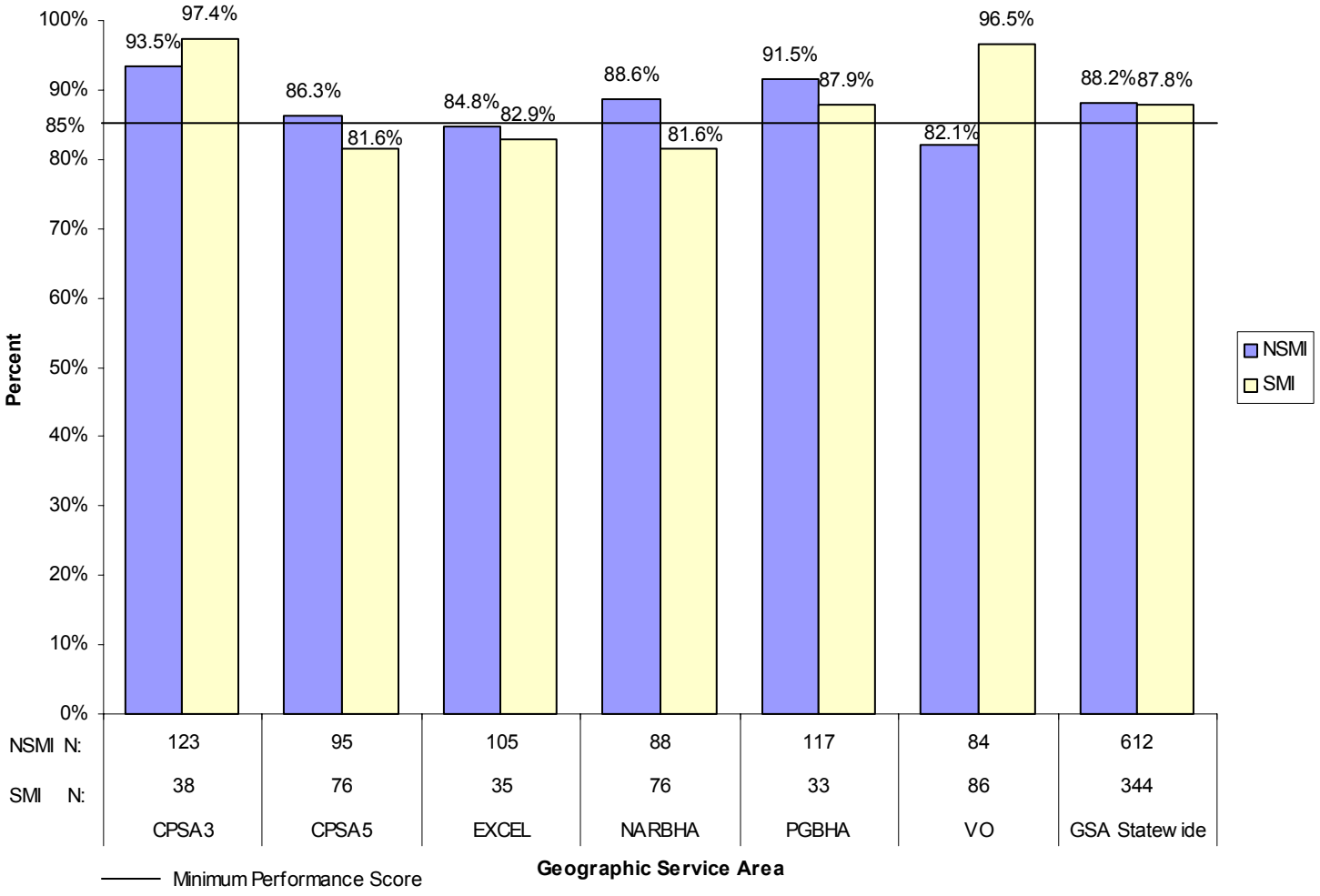
Standard 21 | Services are provided in a timeframe responsive to the urgency of the member's need.

APPENDIX B. SMI and Non-SMI Graphs by GSA

Appendix B contains the bar graphs for each of the standards, illustrating the SMI and non-SMI results for that standard by GSA.

Standard 1

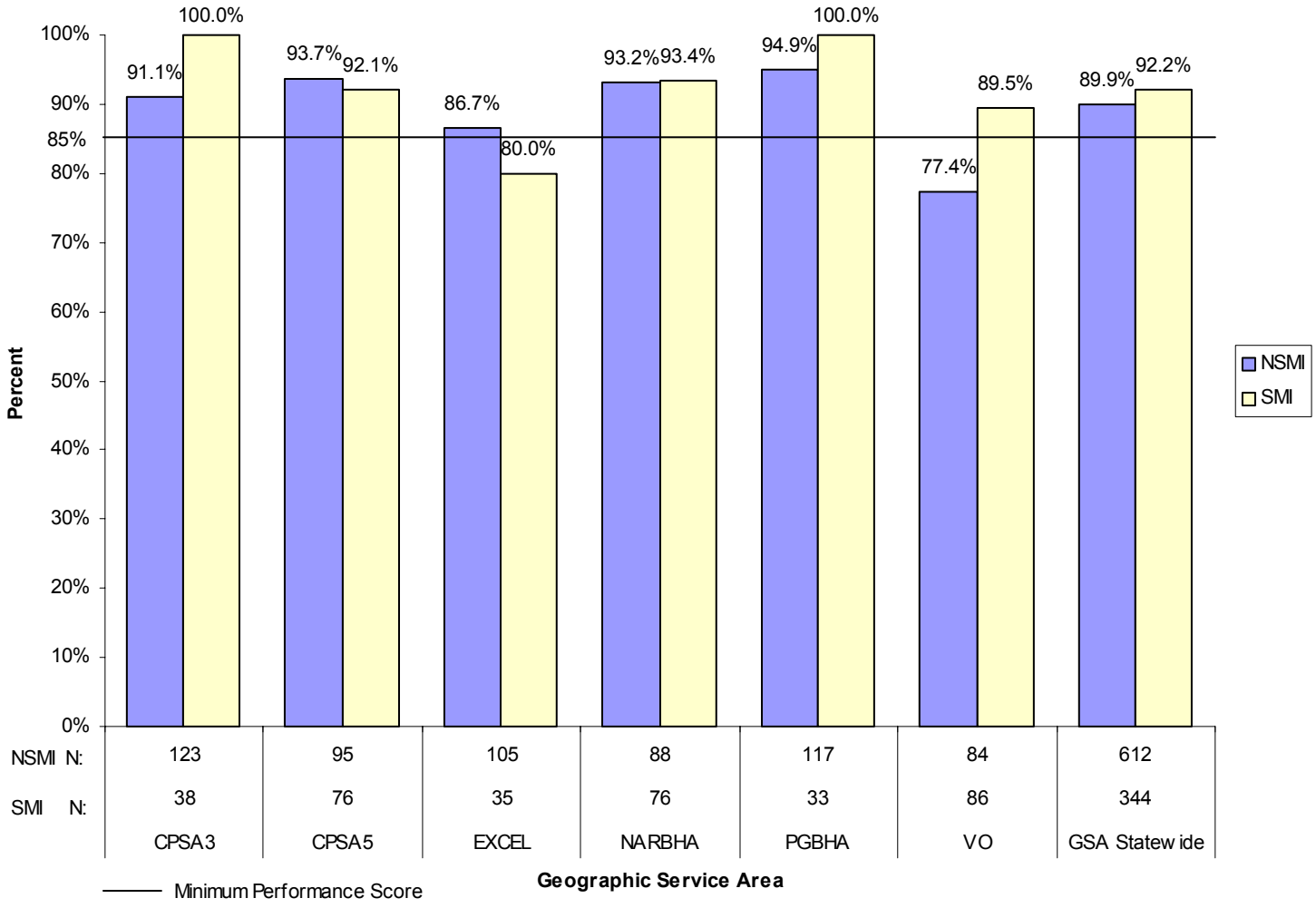
Figure B-1—ADHS Independent Case Review 2002: Standard 1



Standard 1 Assessments are sufficiently comprehensive for the development of functional treatment recommendations.

Standard 2

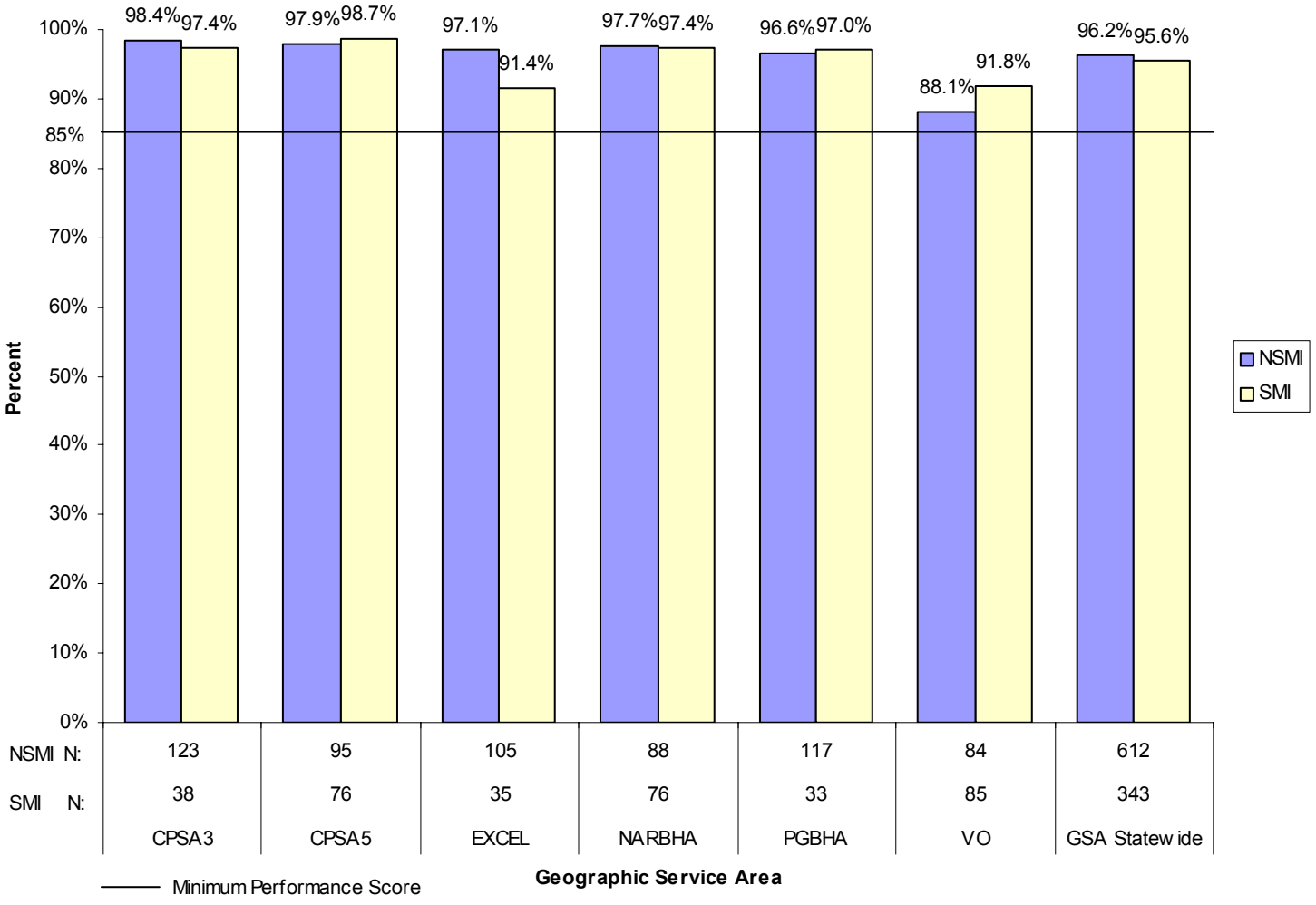
Figure B-2—ADHS Independent Case Review 2002: Standard 2



Standard 2 The types and intensity of services are provided based upon the needs identified in the individual's assessment and treatment recommendations.

Standard 3a

Figure B-3—ADHS Independent Case Review 2002: Standard 3a

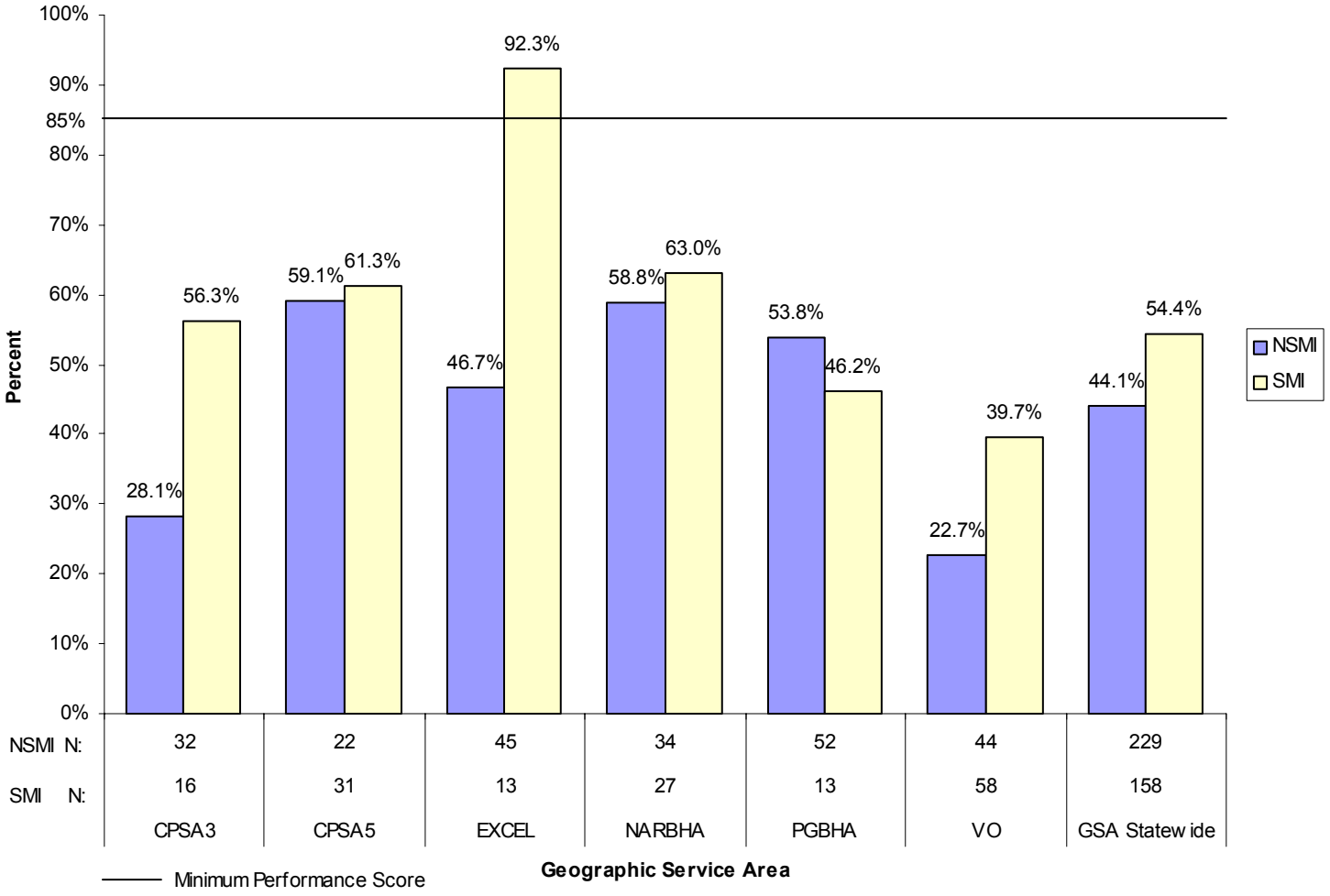


Standard 3a Staff actively engage the following in the treatment planning process:

a. Individual

Standard 3b

Figure B-4—ADHS Independent Case Review 2002: Standard 3b

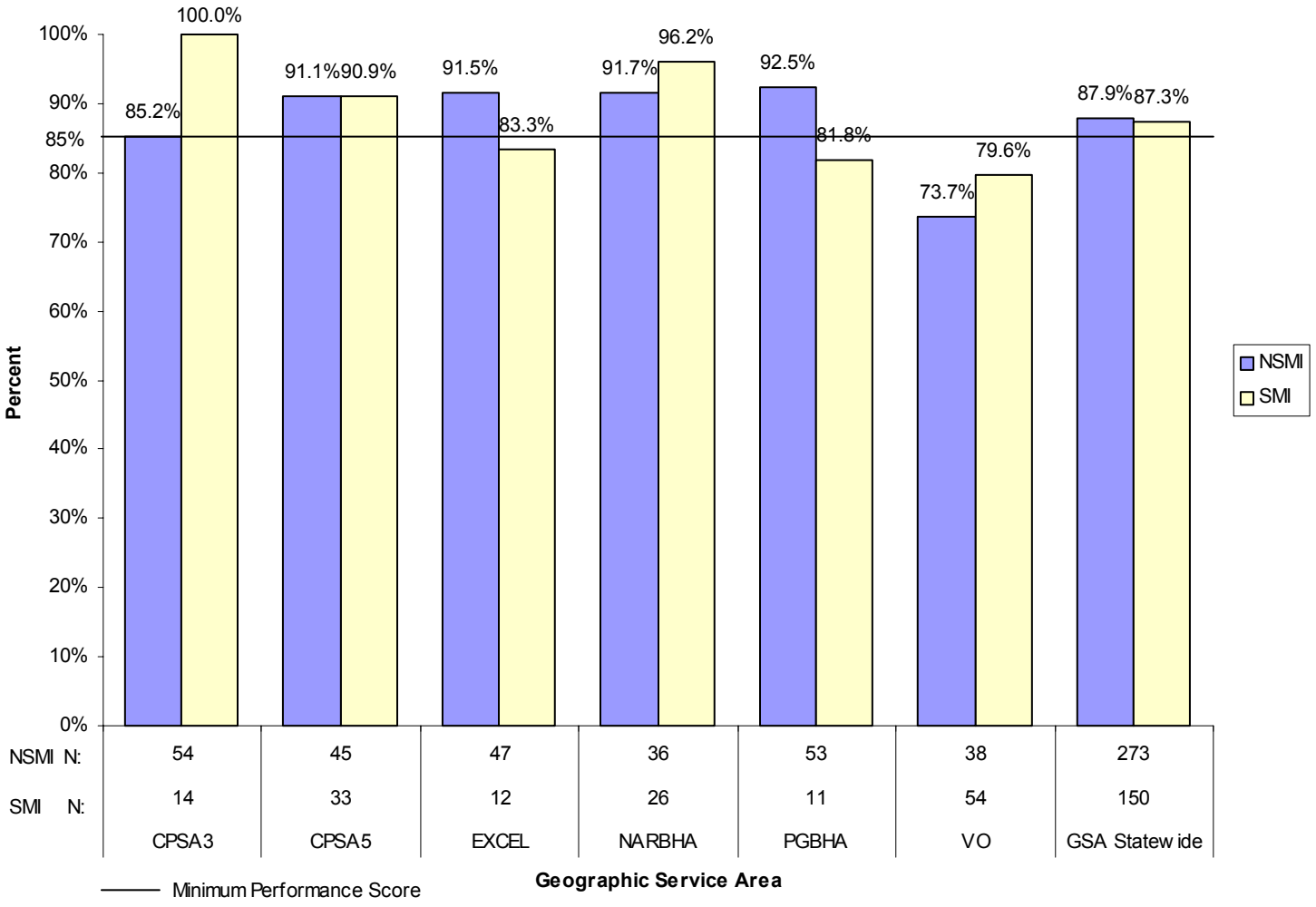


Standard 3b Staff actively engage the following in the treatment planning process:

b. Family

Standard 3c

Figure B-5—ADHS Independent Case Review 2002: Standard 3c

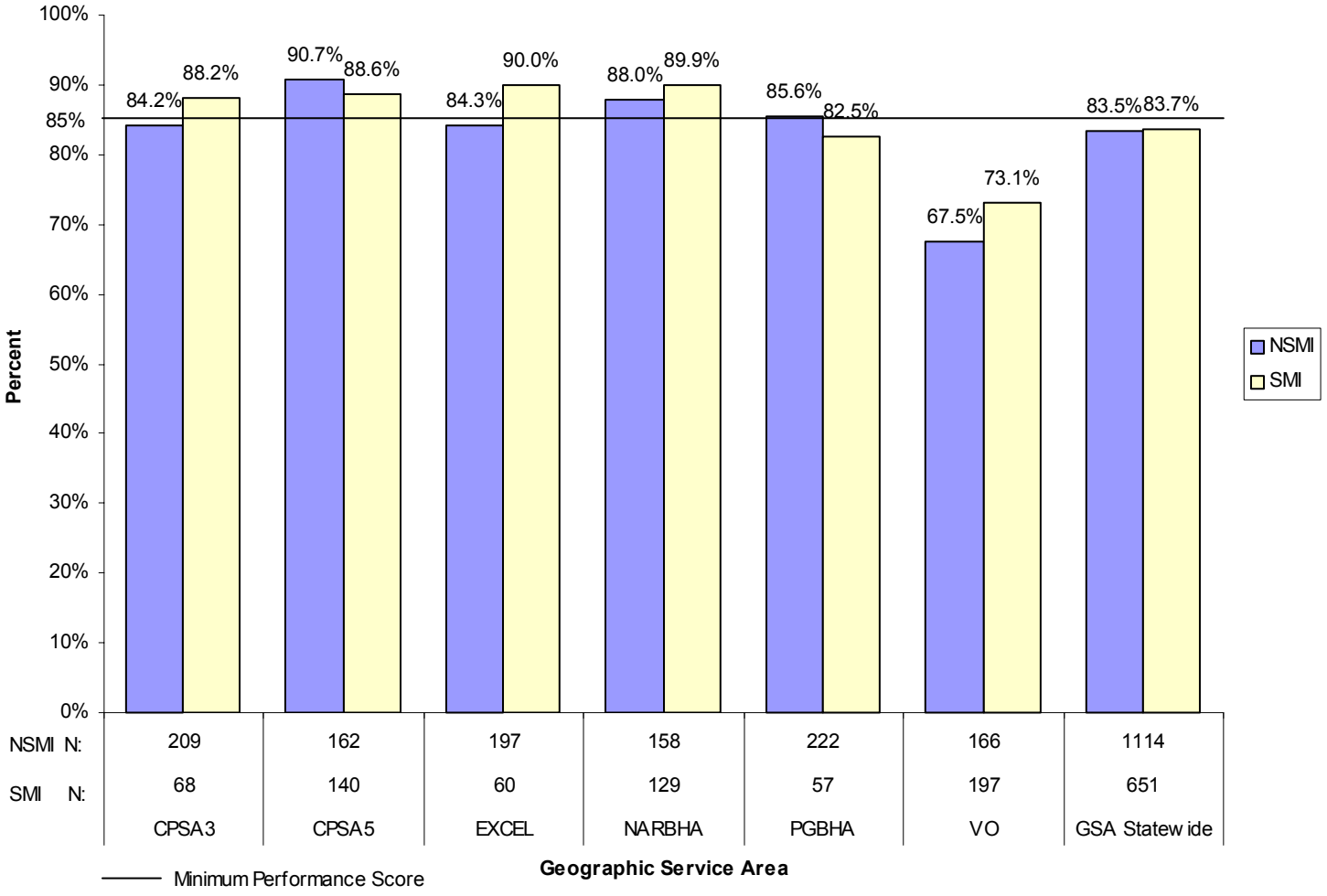


Standard 3c Staff actively engage the following in the treatment planning process:

c. Other agencies

Standard 3a–c

Figure B-6—ADHS Independent Case Review 2002: Standard 3a–c



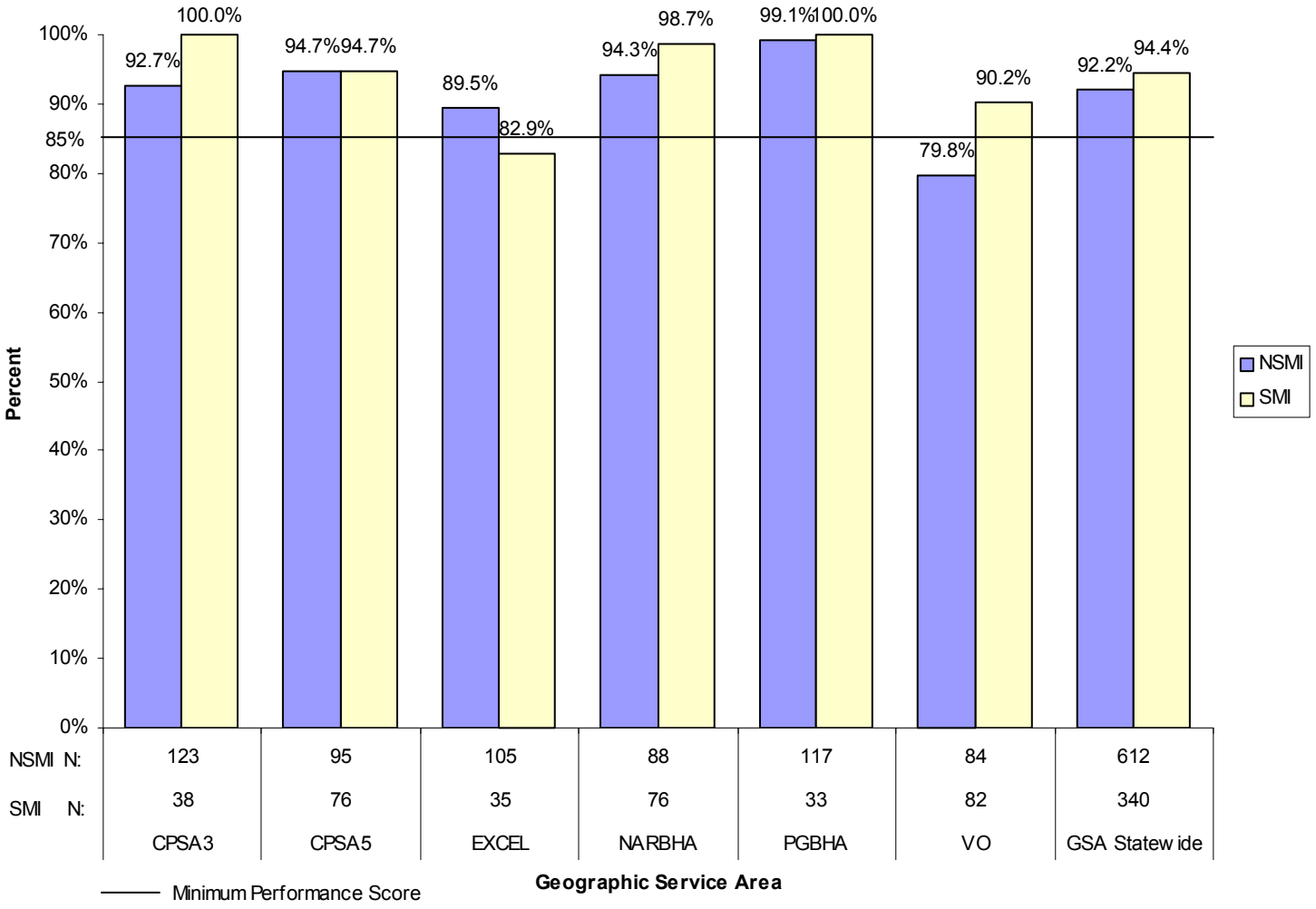
Standard 3a–c

Staff actively engage the following in the treatment planning process:

a. Individual
b. Family
c. Other agencies

Standard 4

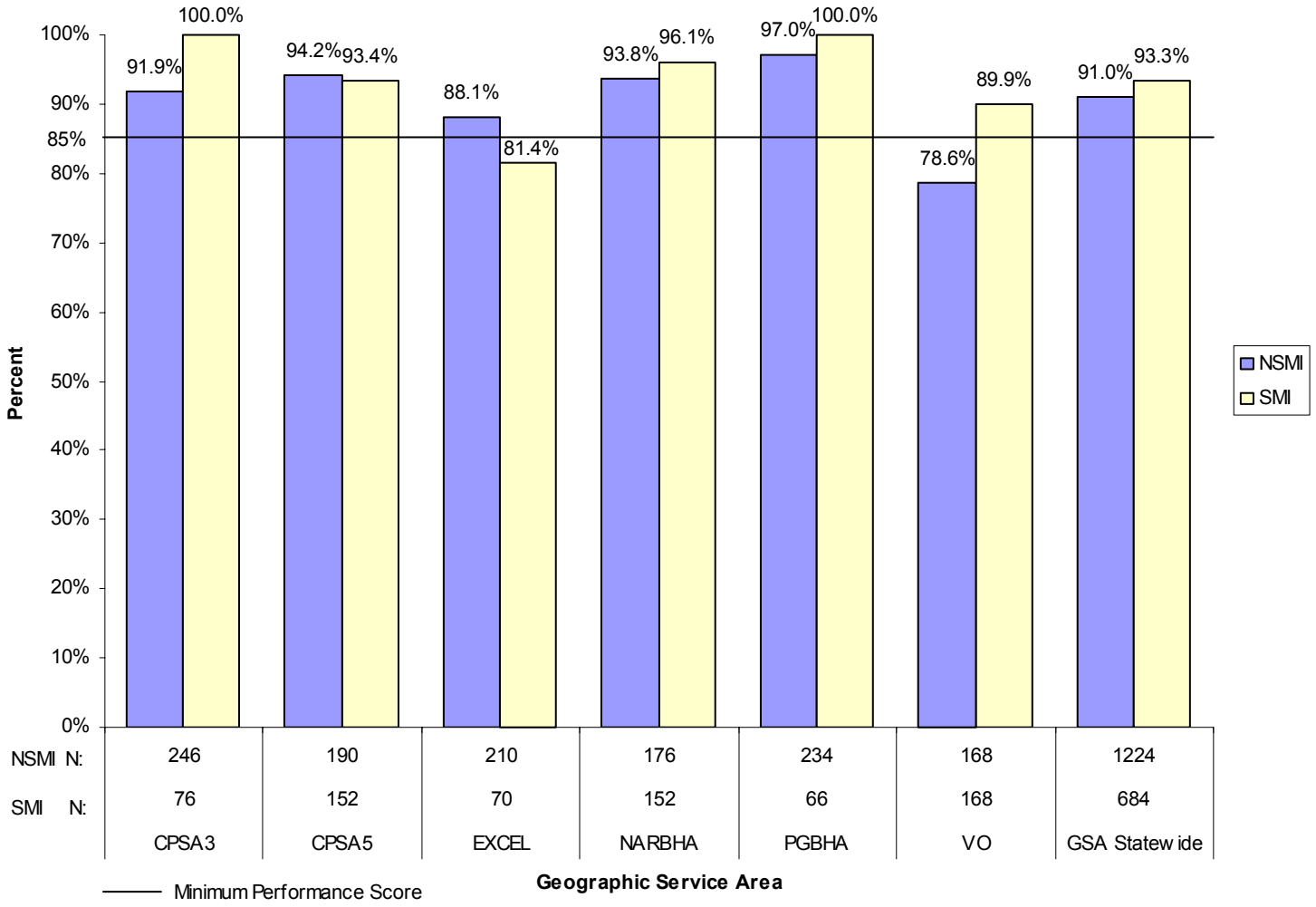
Figure B-7—ADHS Independent Case Review 2002: Standard 4



Standard 4	Case management services are provided based on the individual's assessment and treatment recommendations.

Standards 2 and 4

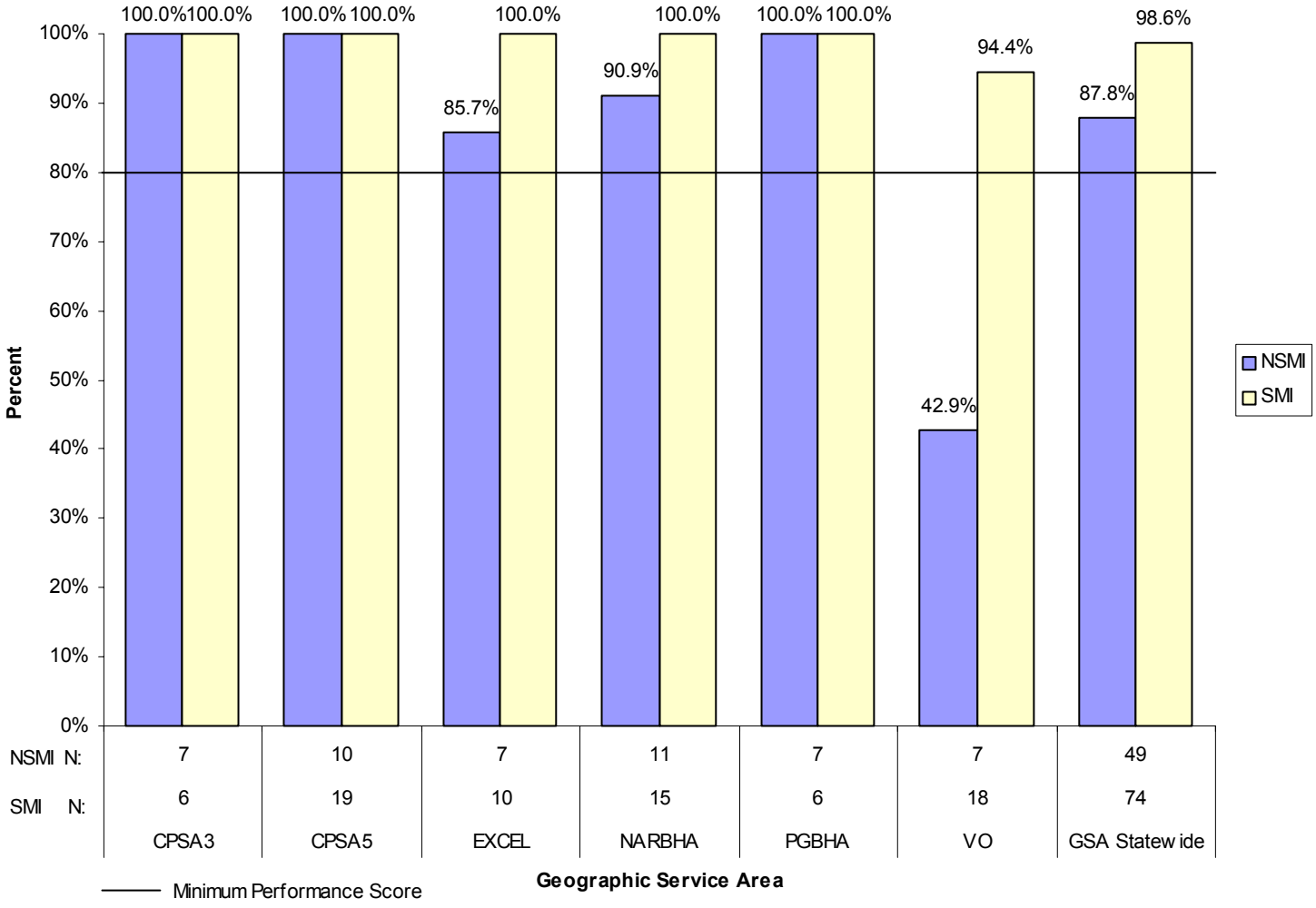
Figure B-8—ADHS Independent Case Review 2002: Standards 2 and 4



Standards 2 & 4 | This chart is the roll-up of Standards 2 and 4.

Standard 5a

Figure B-9—ADHS Independent Case Review 2002: Standard 5a



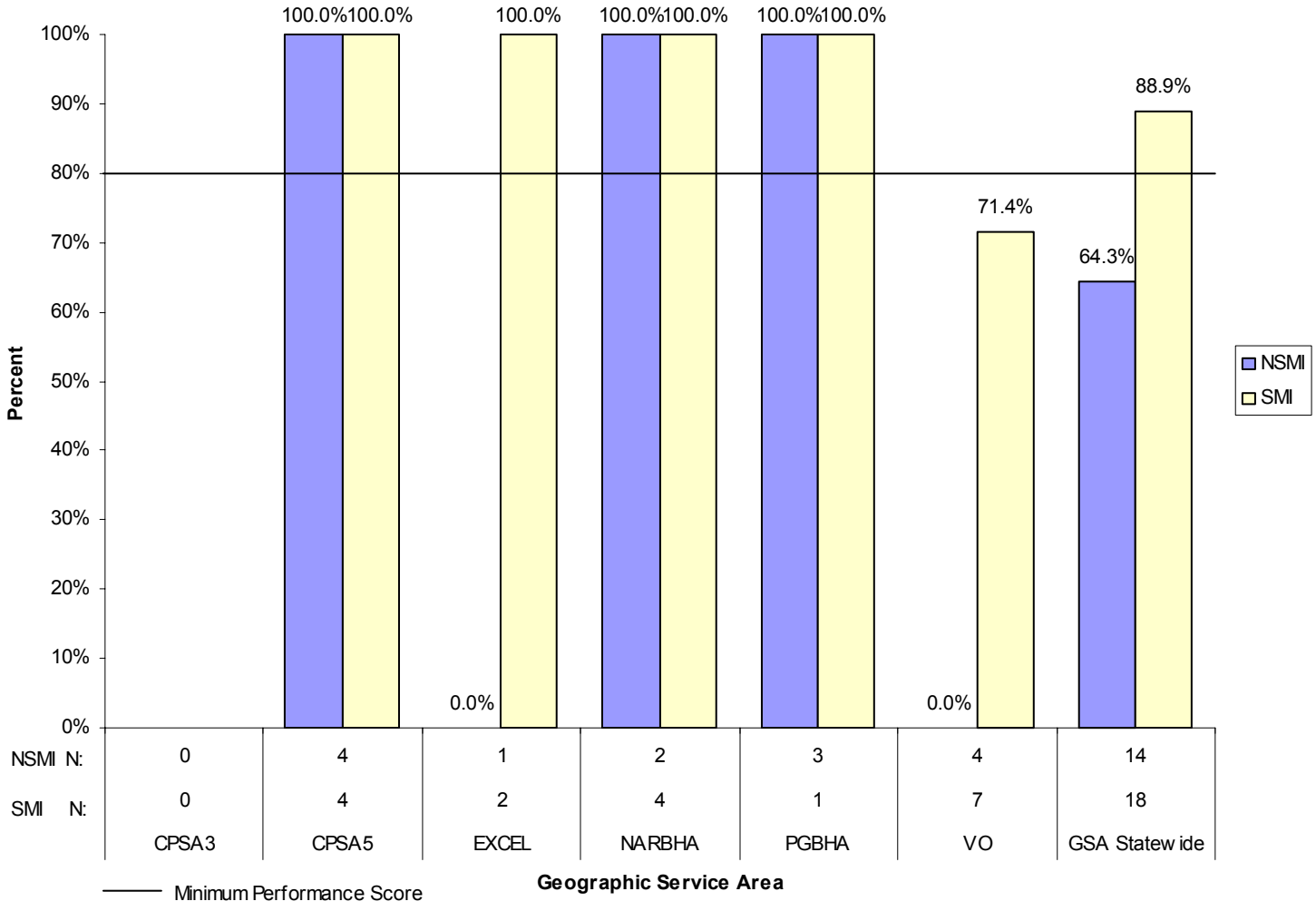
Standard 5a

Outreach/follow-up occurs after:

a. Discharge from inpatient

Standard 5b

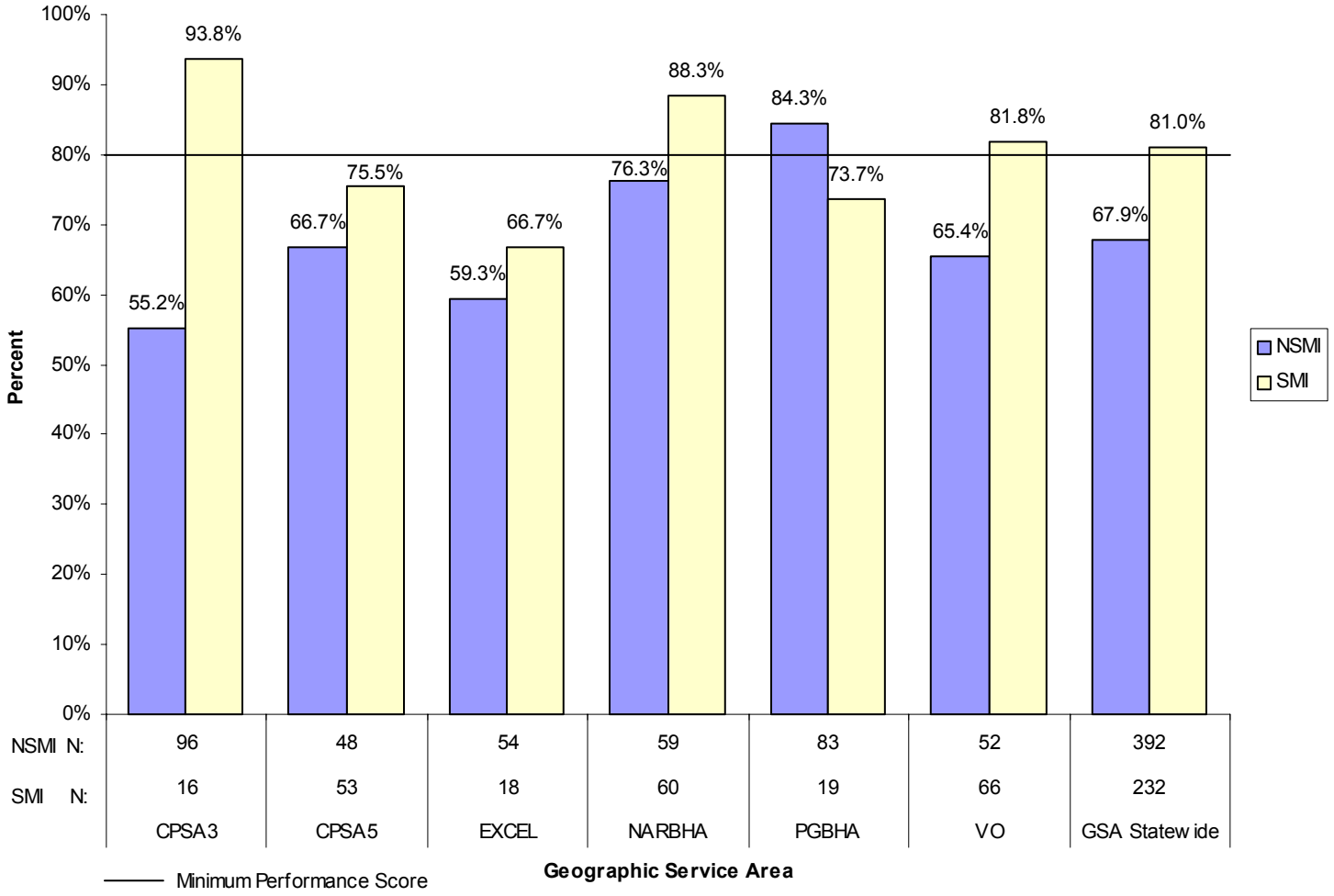
Figure B-10—ADHS Independent Case Review 2002: Standard 5b



Standard 5b | Outreach/follow-up occurs after:
b. Discharge from residential

Standard 5c

Figure B-11—ADHS Independent Case Review 2002: Standard 5c



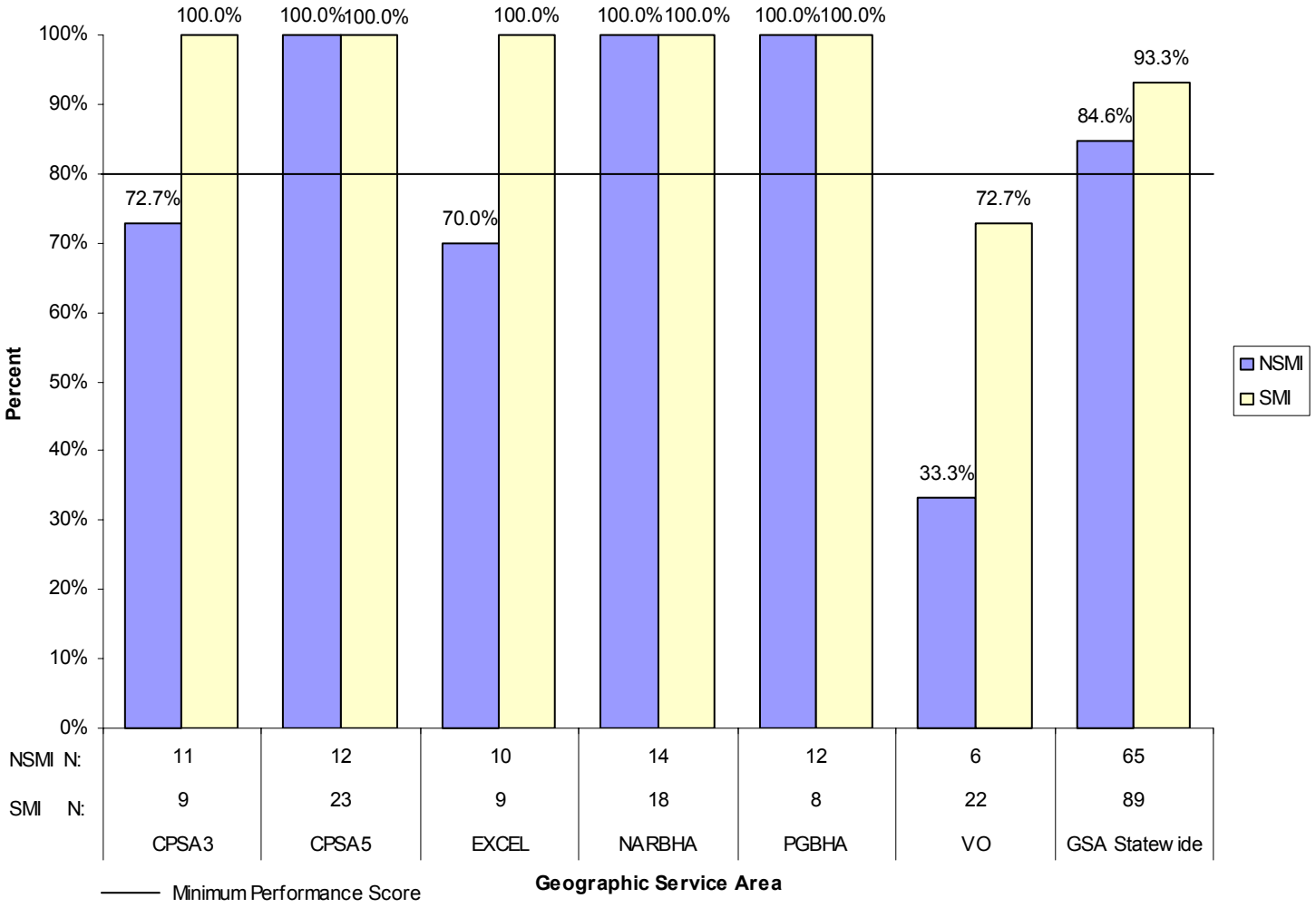
Standard 5c

Outreach/follow-up occurs after:

c. Missed appointments

Standard 5d

Figure B-12—ADHS Independent Case Review 2002: Standard 5d



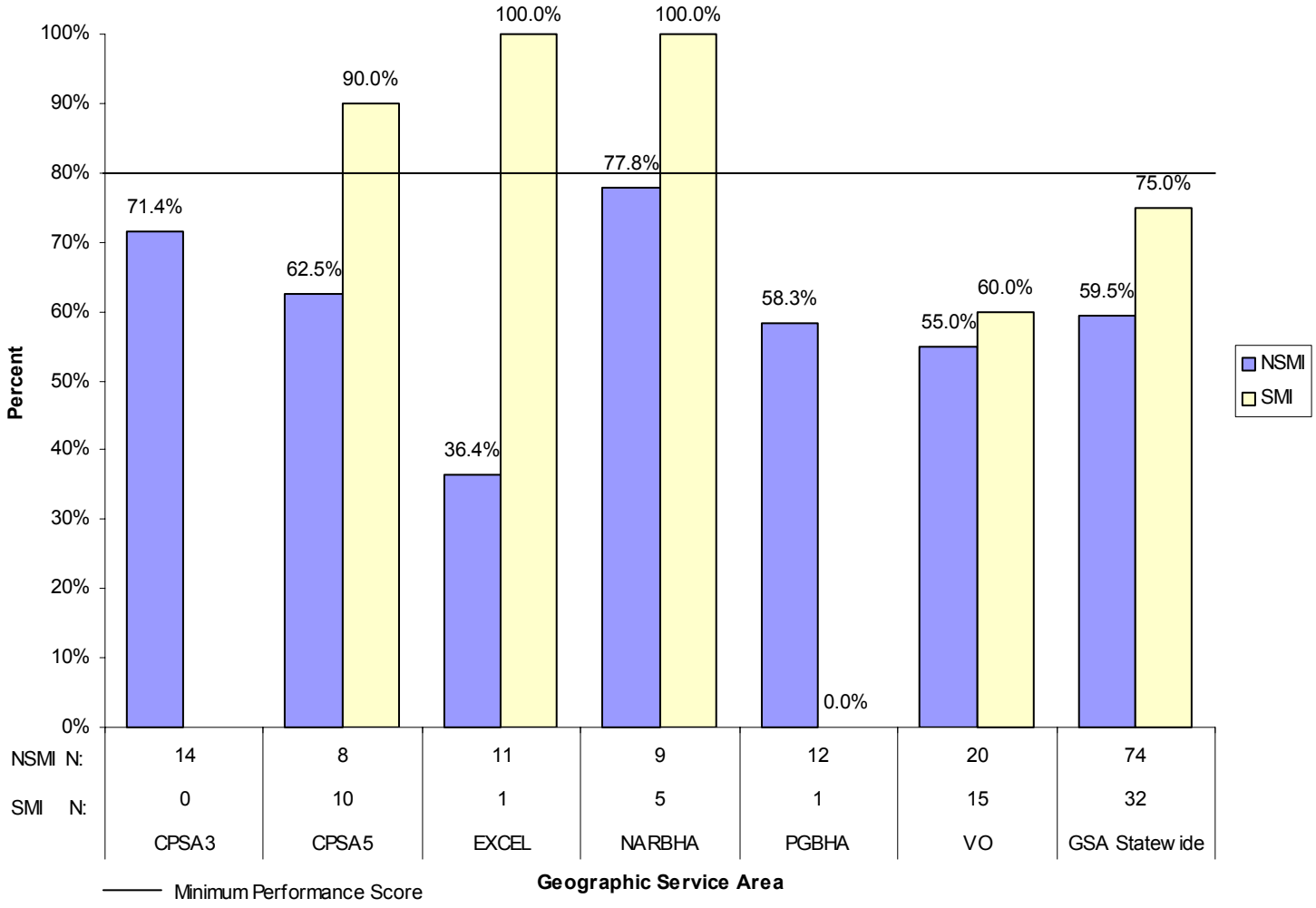
Standard 5d

Outreach/follow-up occurs after:

d. Crisis episodes

Standard 5e

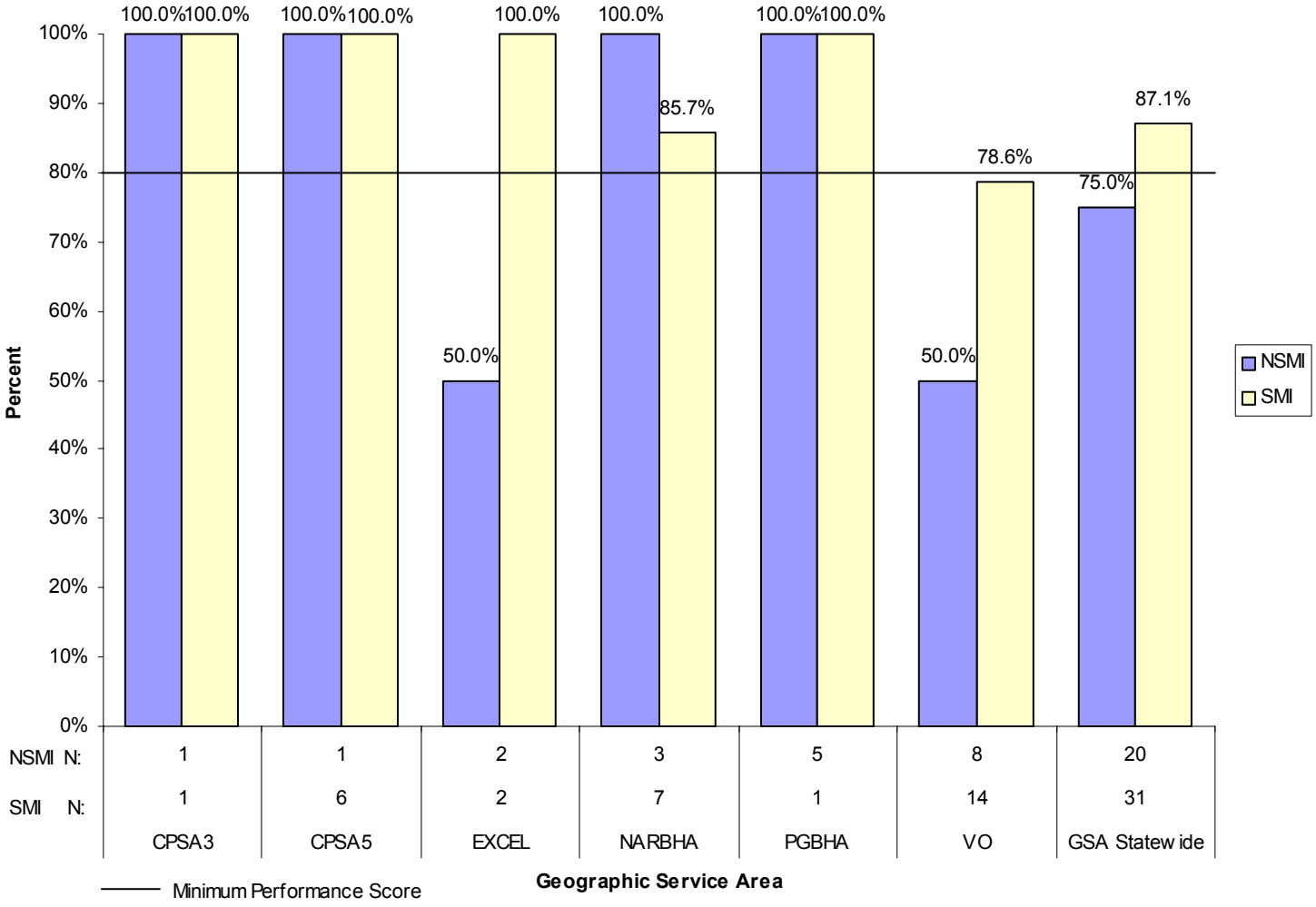
Figure B-13—ADHS Independent Case Review 2002: Standard 5e



Standard 5e	Outreach/follow-up occurs after: e. Service refusal

Standard 5f

Figure B-14—ADHS Independent Case Review 2002: Standard 5f



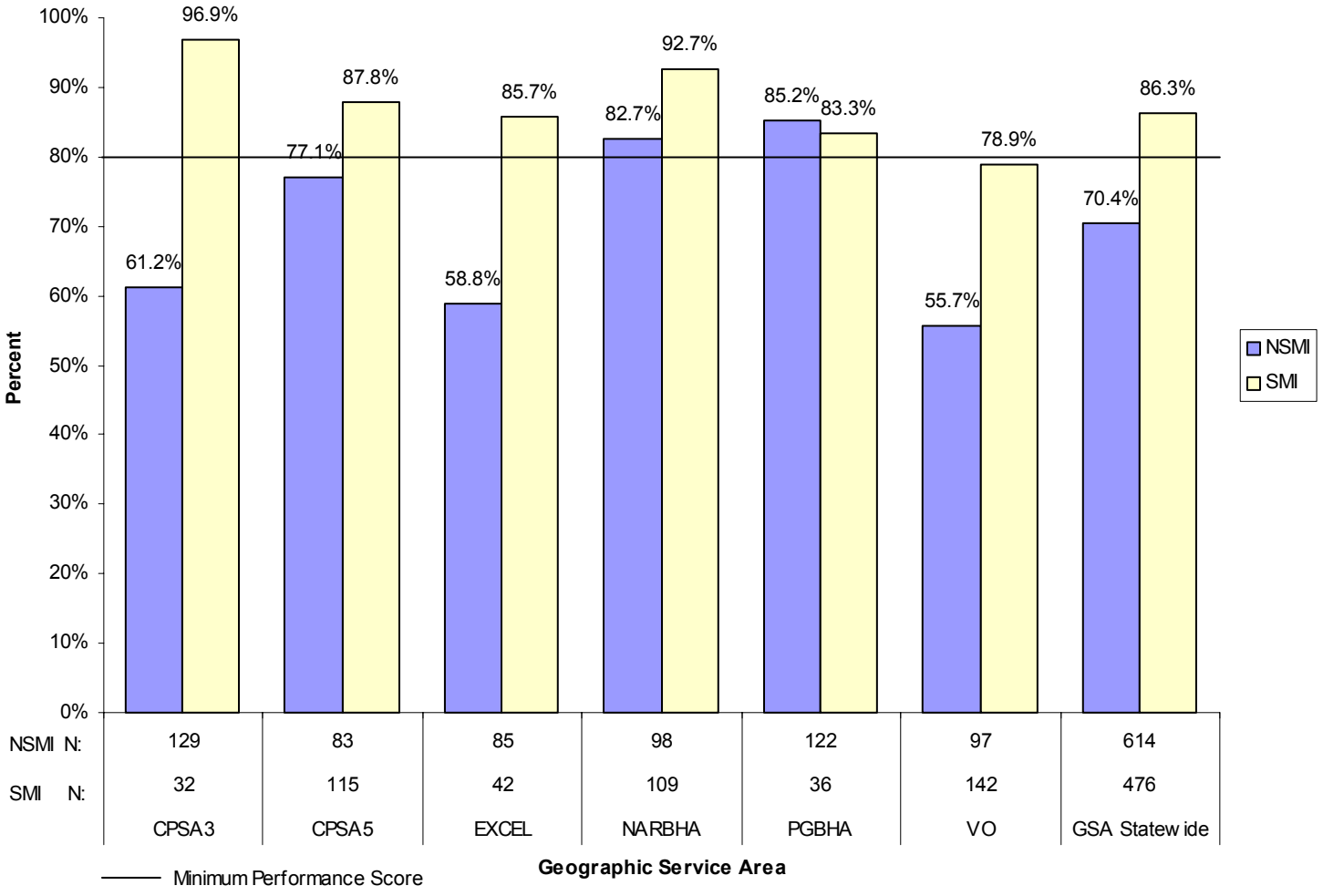
Standard 5f

Outreach/follow-up occurs after:

f. Medication refusal

Standard 5a–f

Figure B-15—ADHS Independent Case Review 2002: Standard 5a–f



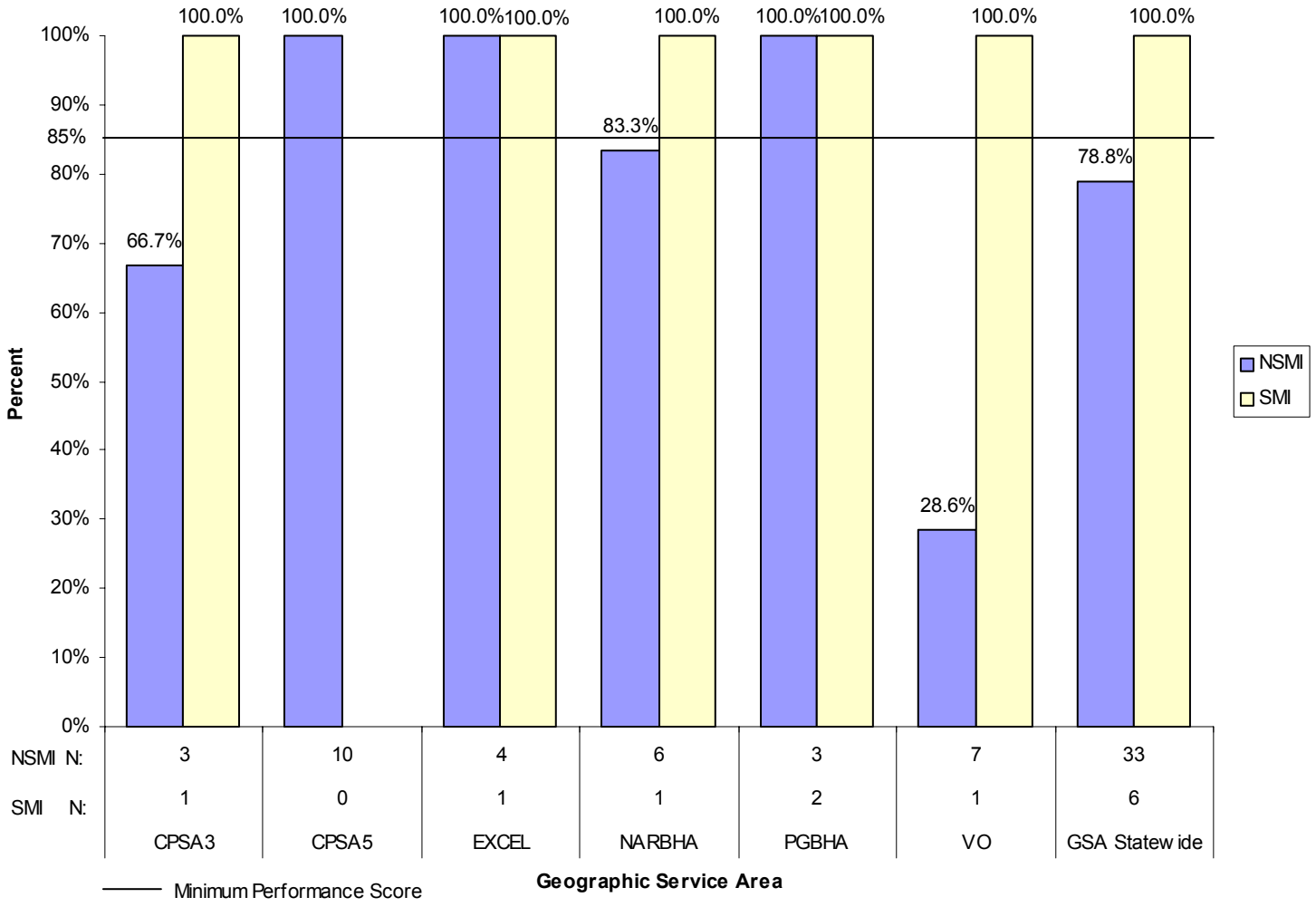
Standard 5a–f

Outreach/follow-up occurs after:

a. Discharge from inpatient
b. Discharge from residential
c. Missed appointments
d. Crisis episodes
e. Service refusal
f. Medication refusal

Standard 6 (For DDD Individuals Only)

Figure B-16—ADHS Independent Case Review 2002: Standard 6

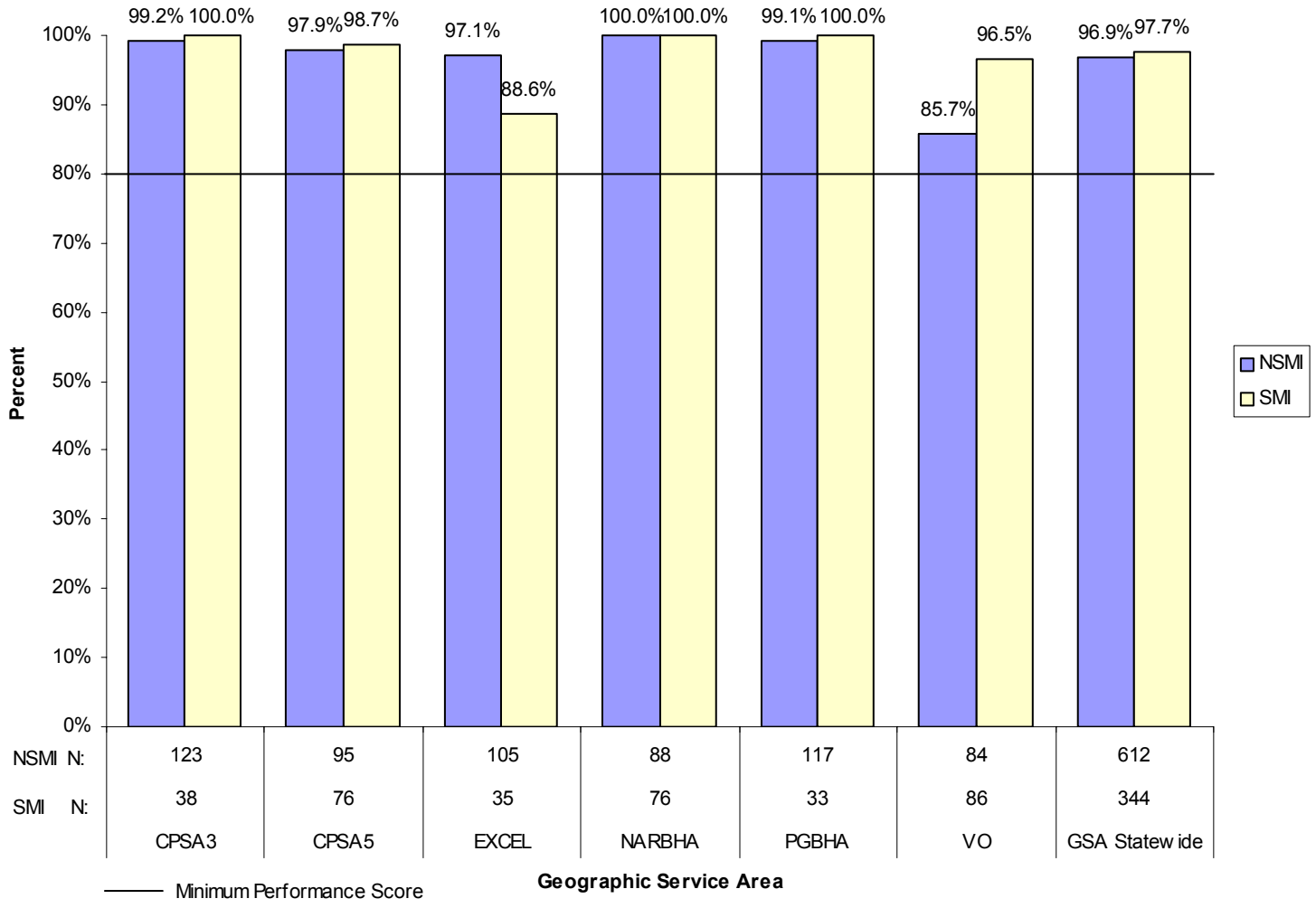


For DDD Individuals Only

Standard 6 Individuals with identified specialized service needs are referred for and receive these services.

Standard 7

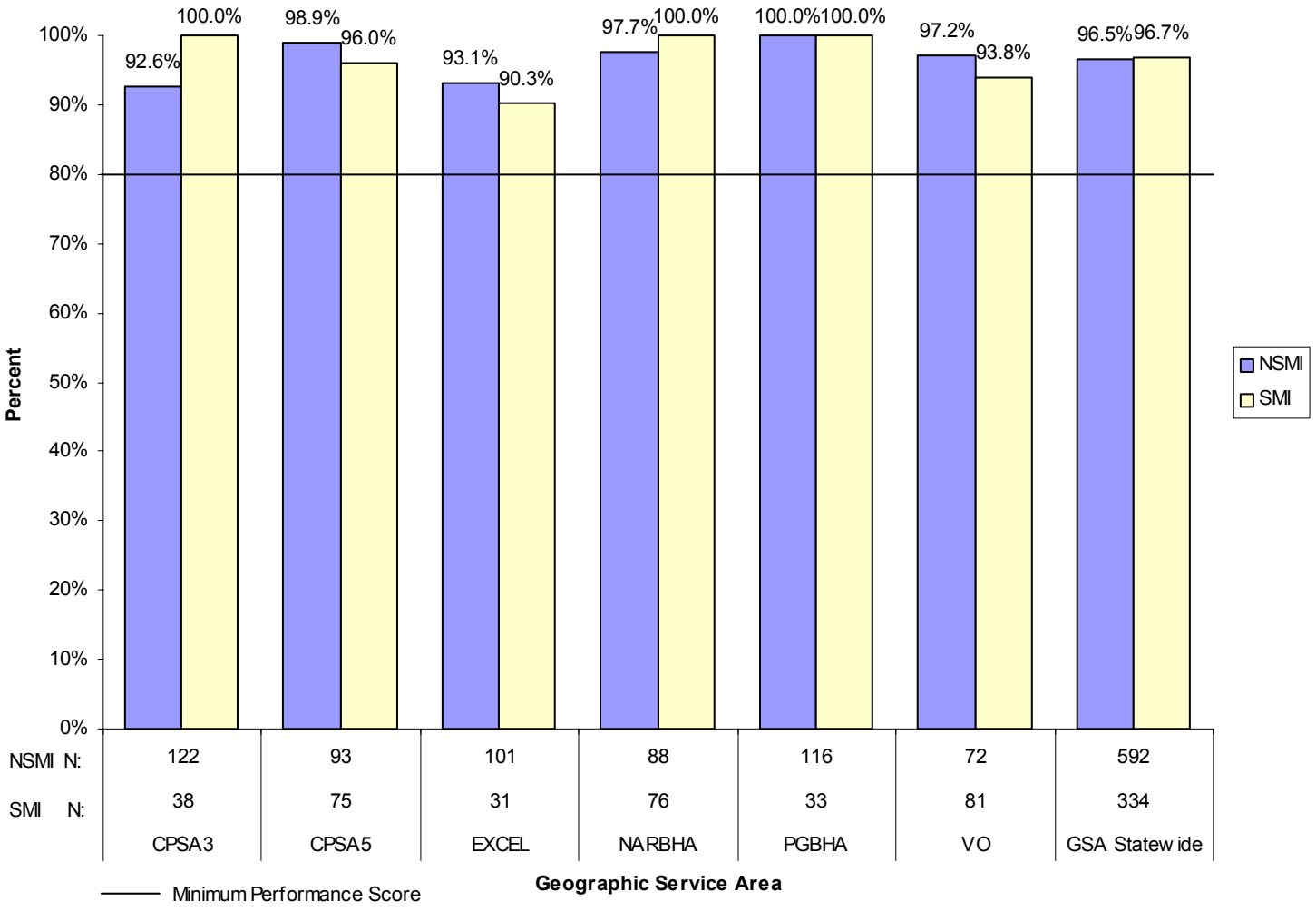
Figure B-17—ADHS Independent Case Review 2002: Standard 7



Standard 7 | The individual has an assigned clinician.

Standard 8

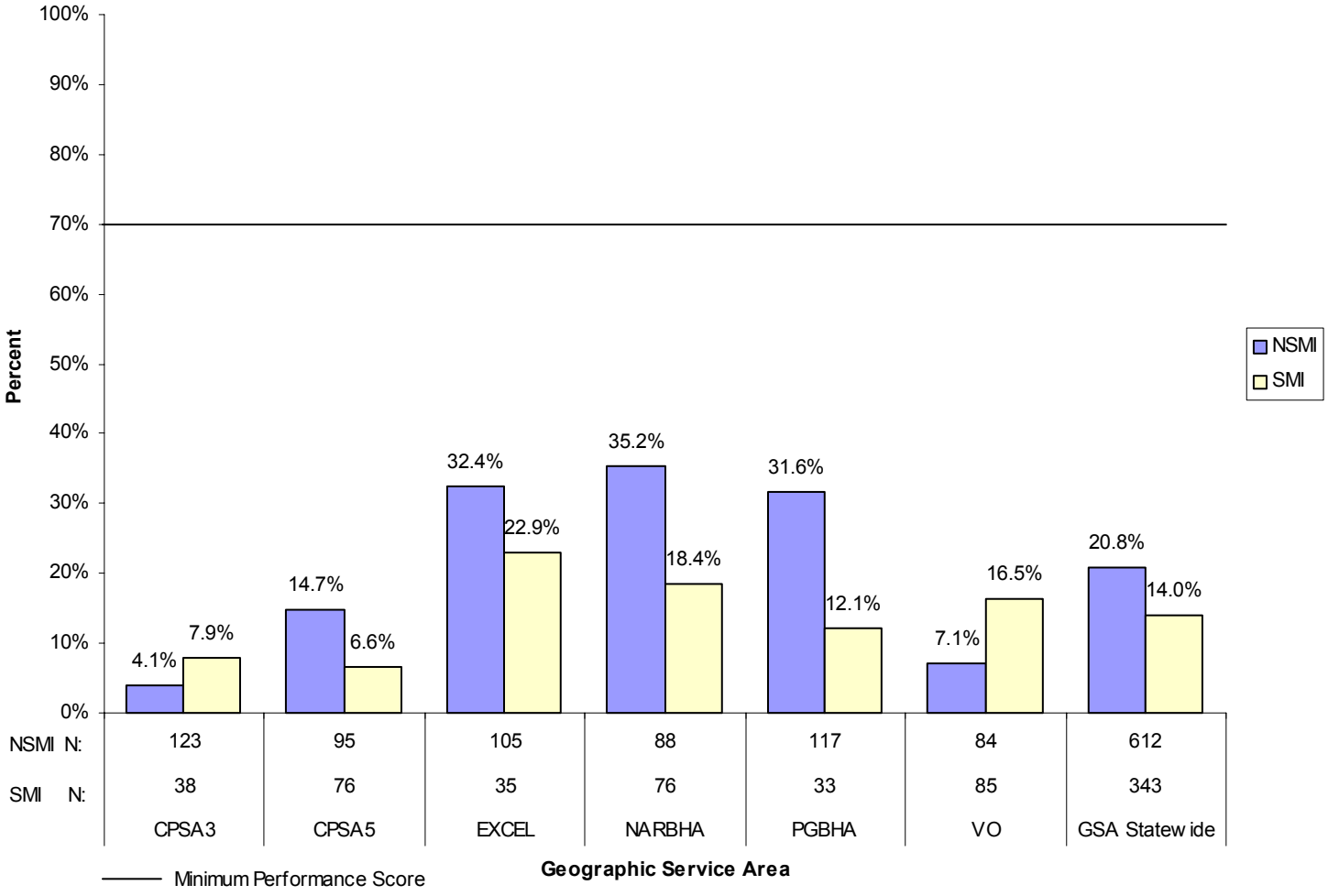
Figure B-18—ADHS Independent Case Review 2002: Standard 8



Standard 8 | The assigned clinician is actively involved in the oversight of the treatment.

Standard 9

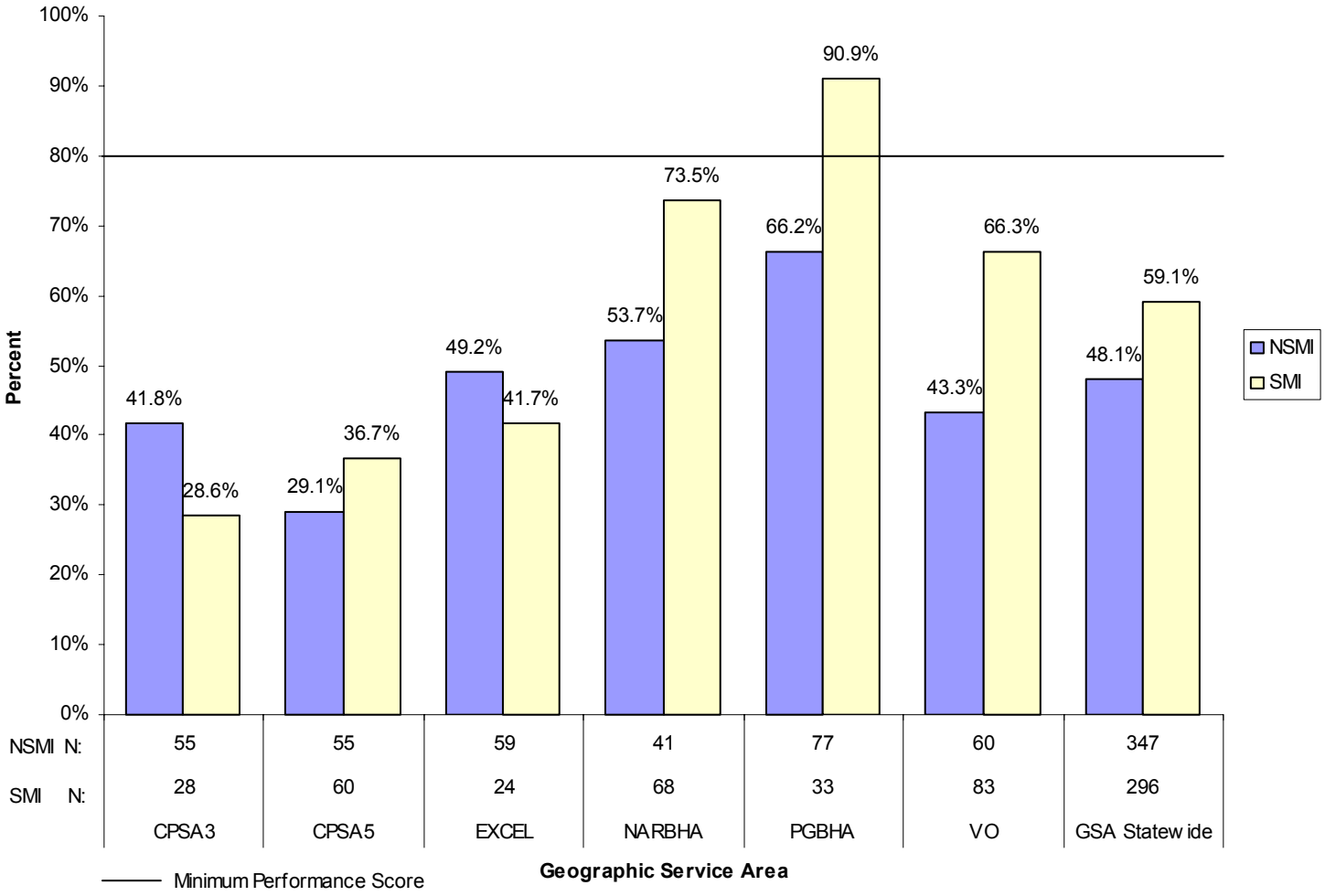
Figure B-19—ADHS Independent Case Review 2002: Standard 9



Standard 9 Individuals'/families' cultural preferences are assessed and included in the development of treatment plans.

Standard 10

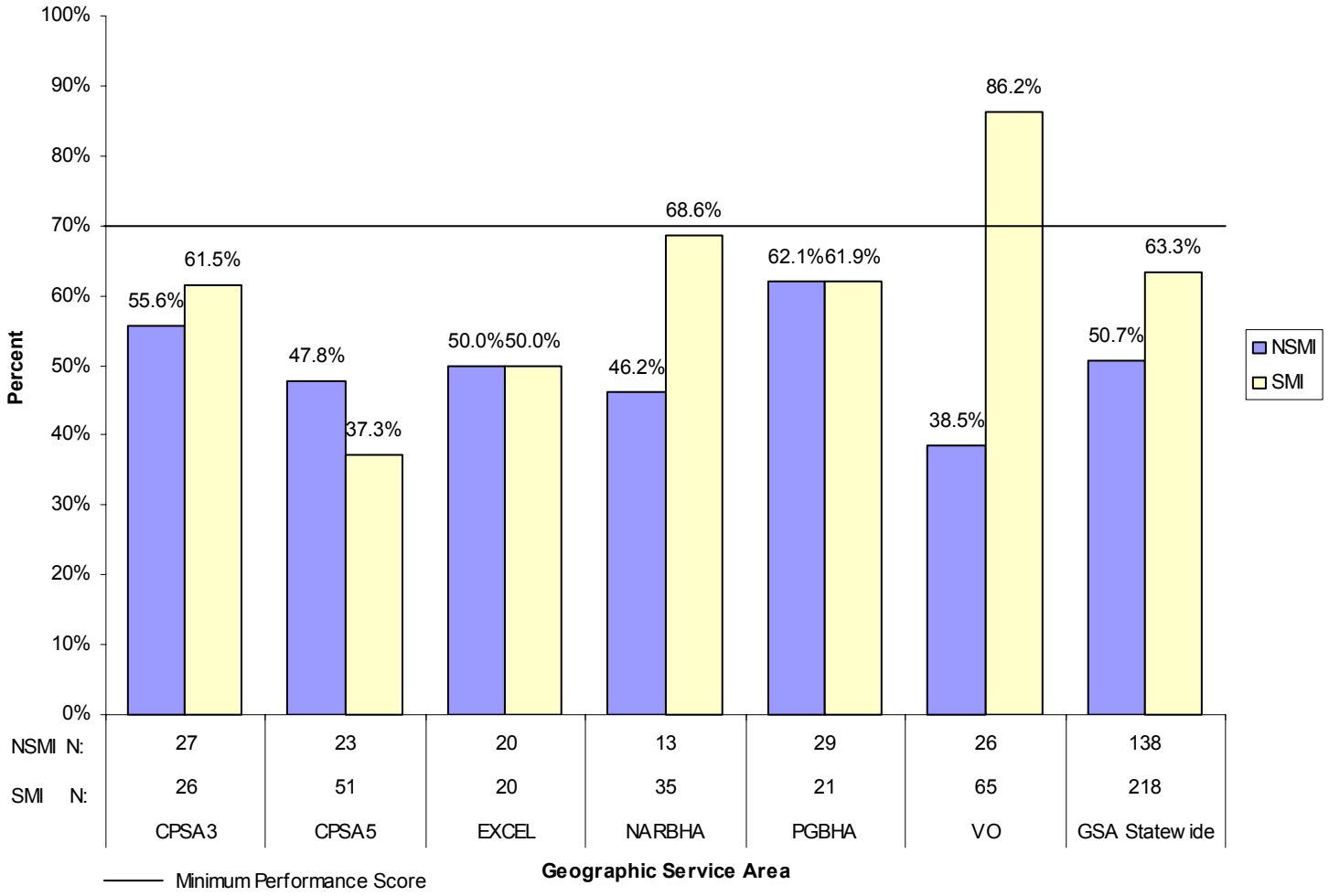
Figure B-20—ADHS Independent Case Review 2002: Standard 10



Standard 10 Individuals and/or parent/guardians are informed about and give consent for prescribed medications.

Standard 11

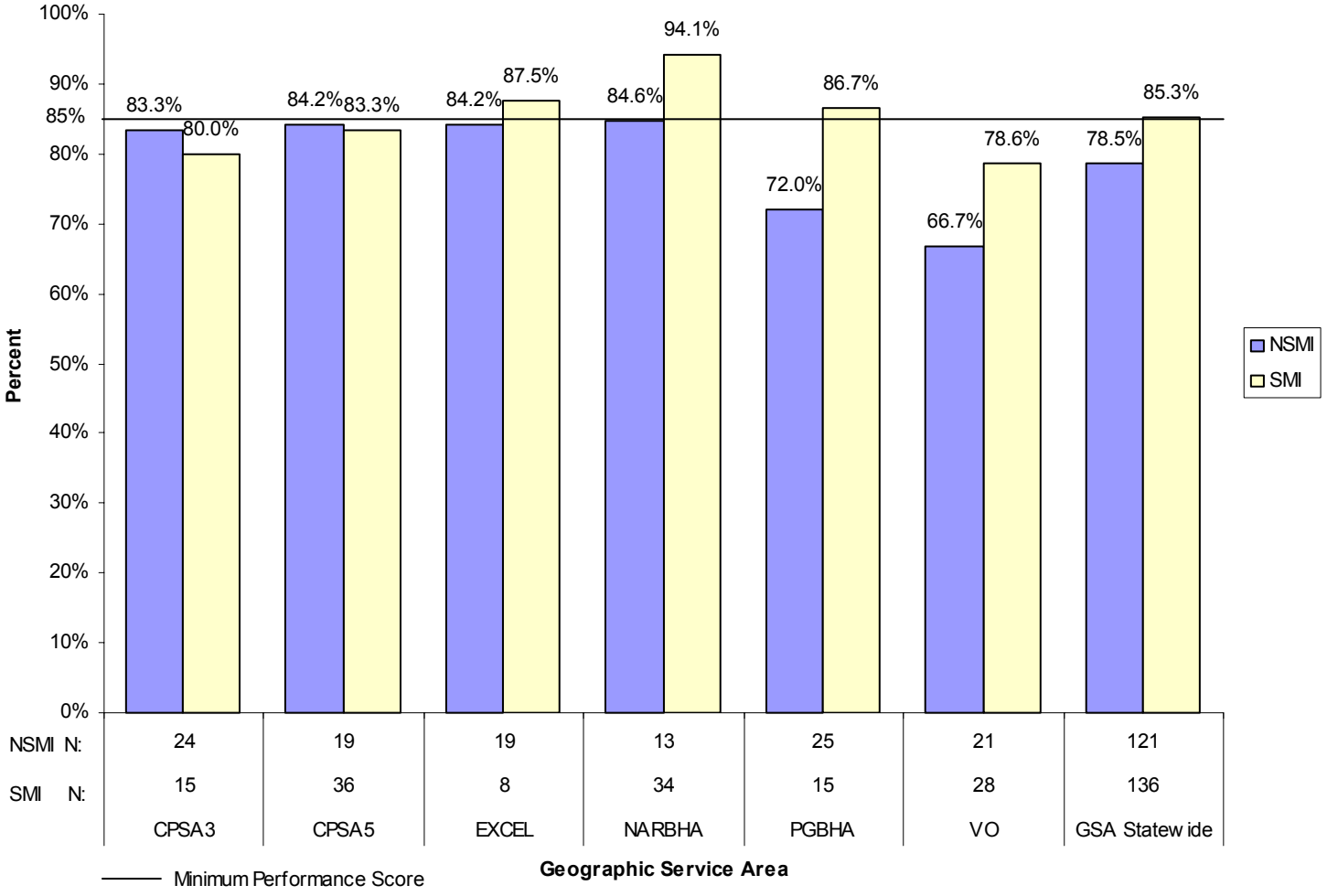
Figure B-21—ADHS Independent Case Review 2002: Standard 11



Standard 11 If the individual has been prescribed anti-psychotic medication, regular assessments for movement disorders are documented.

Standard 12

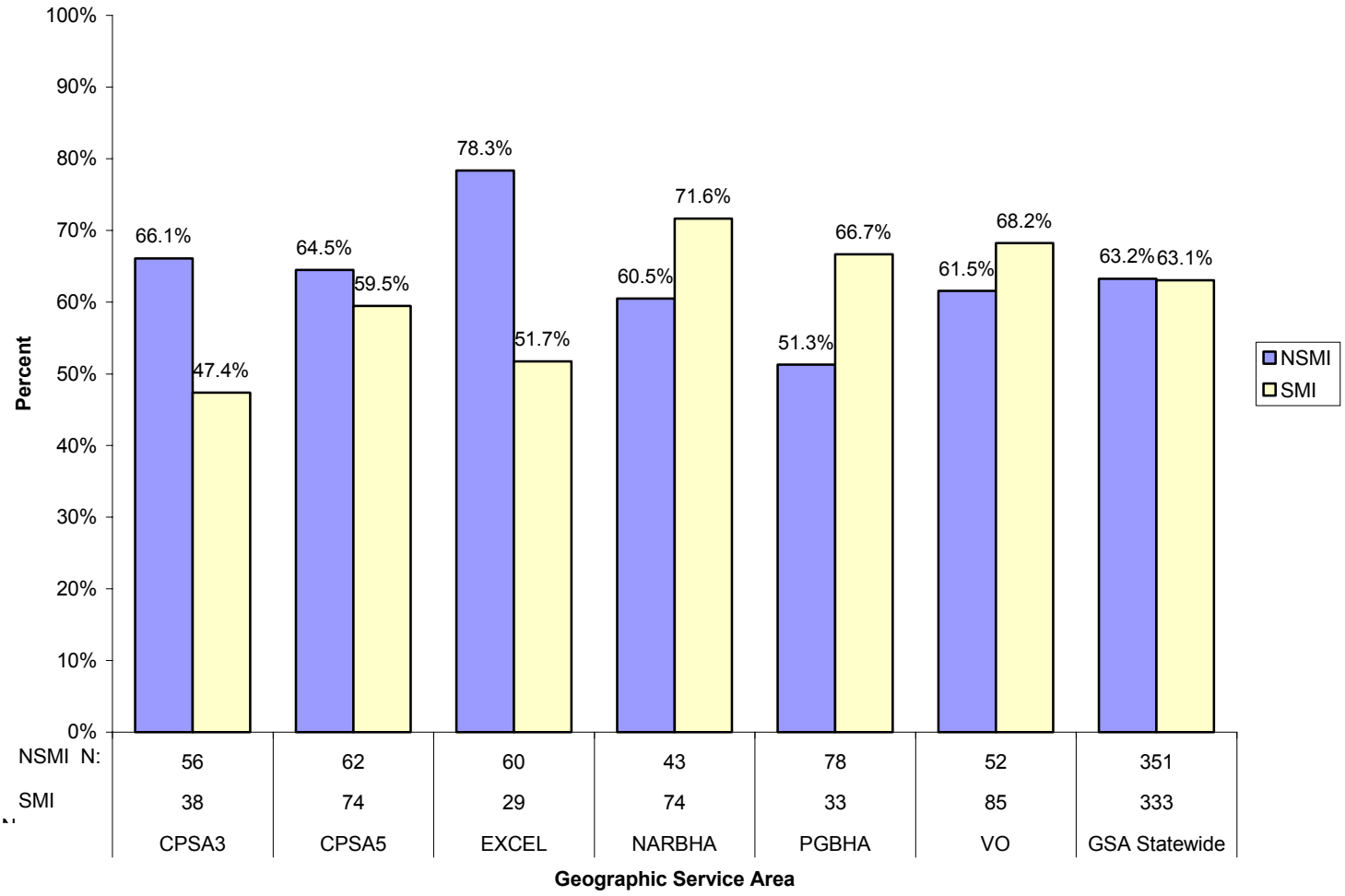
Figure B-22—ADHS Independent Case Review 2002: Standard 12



Standard 12 If the individual has been prescribed psychotropic medications and adverse reactions or side effects are noted, progress notes include documentation of follow-up actions to address adverse effects.

Standard 13

Figure B-23—ADHS Independent Case Review 2002: Standard 13

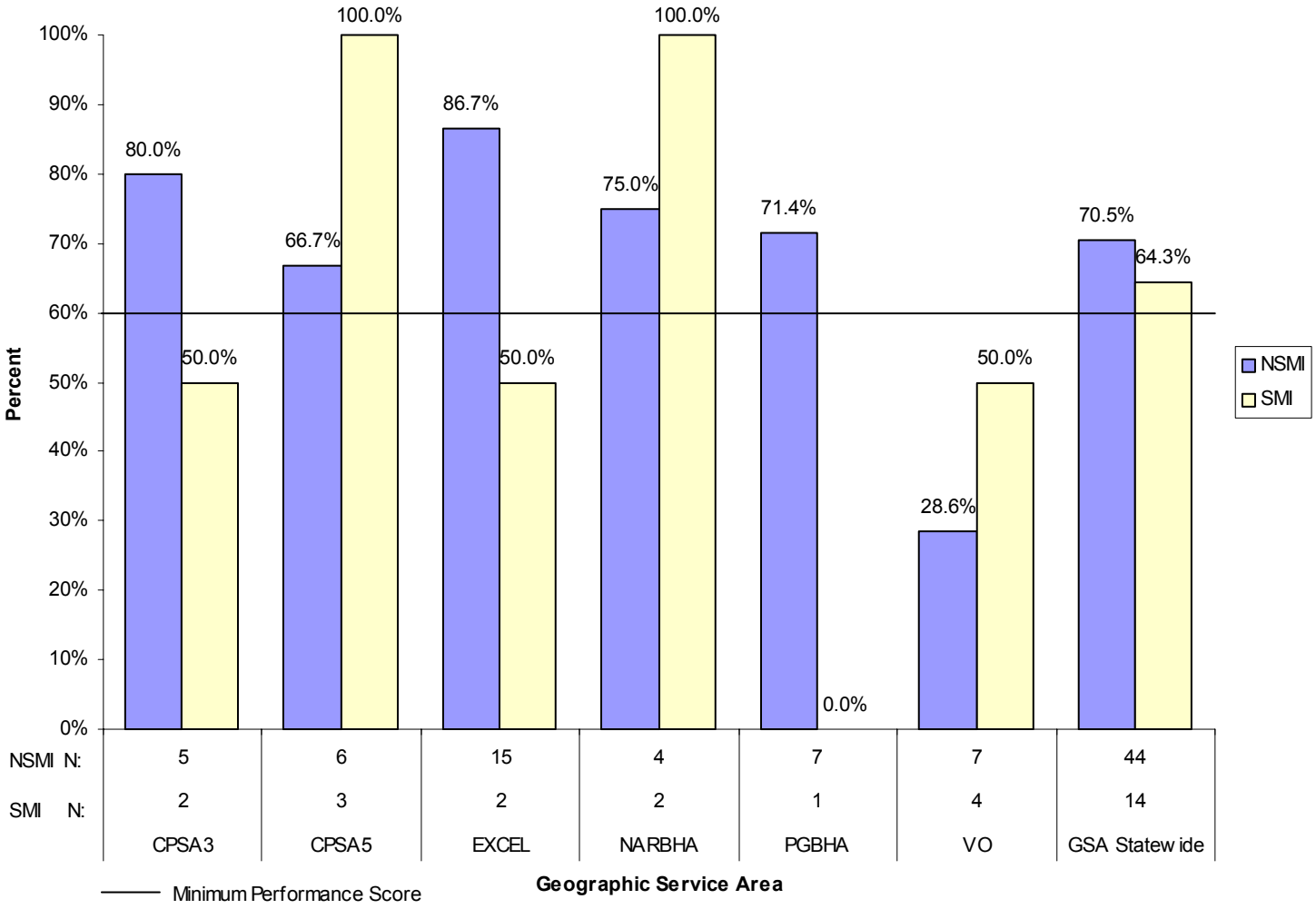


Note: A Minimum Performance Score has not been established for this standard.

Standard 13	If the individual has been prescribed psychotropic medication, the record includes documentation of specific target symptoms.

Standard 14

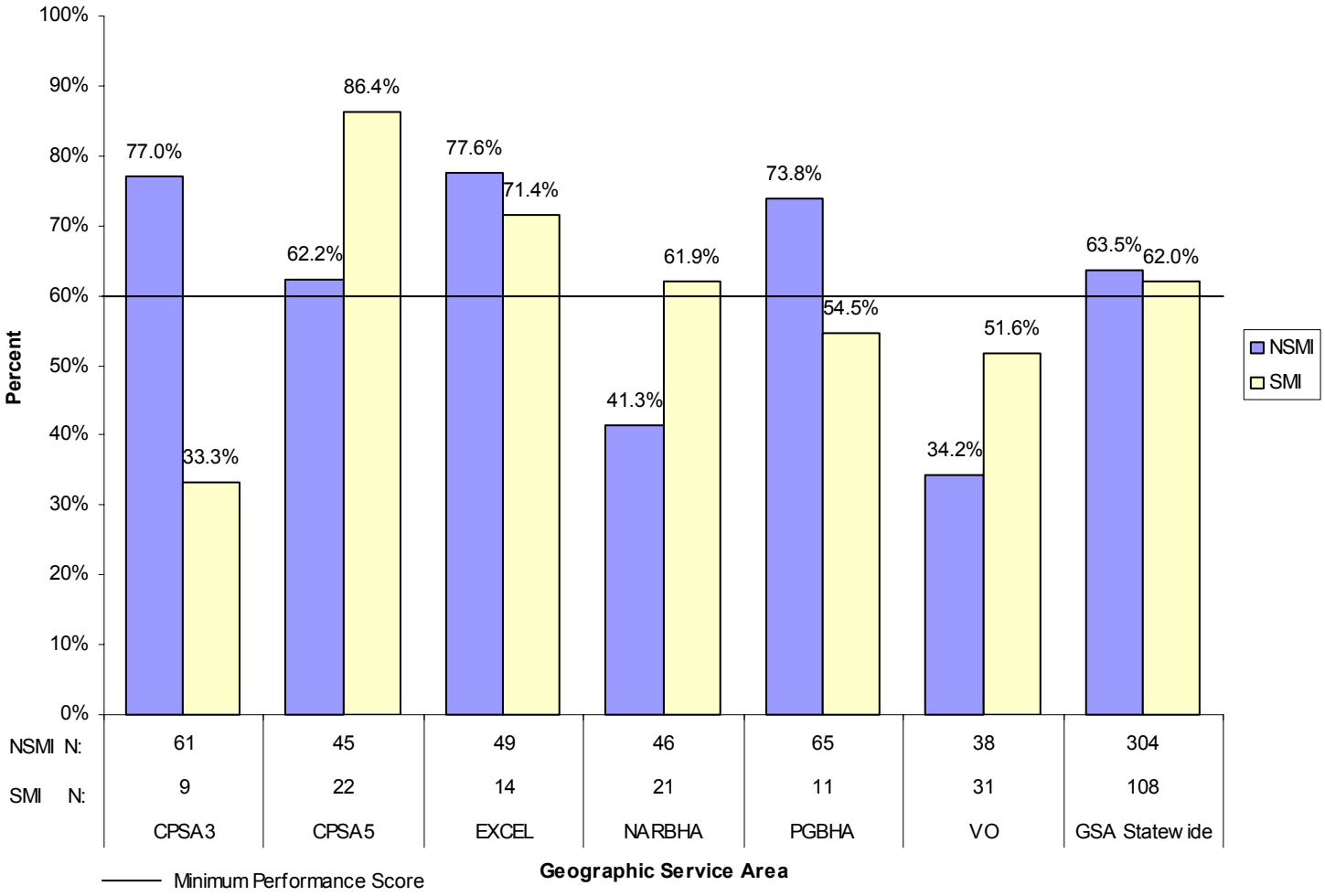
Figure B-24—ADHS Independent Case Review 2002: Standard 14



Standard 14 The disposition of the referral from the PCP or Health Plan is communicated to the PCP or Health Plan within 30 days of receiving the request for service.

Standard 15a

Figure B-25—ADHS Independent Case Review 2002: Standard 15a



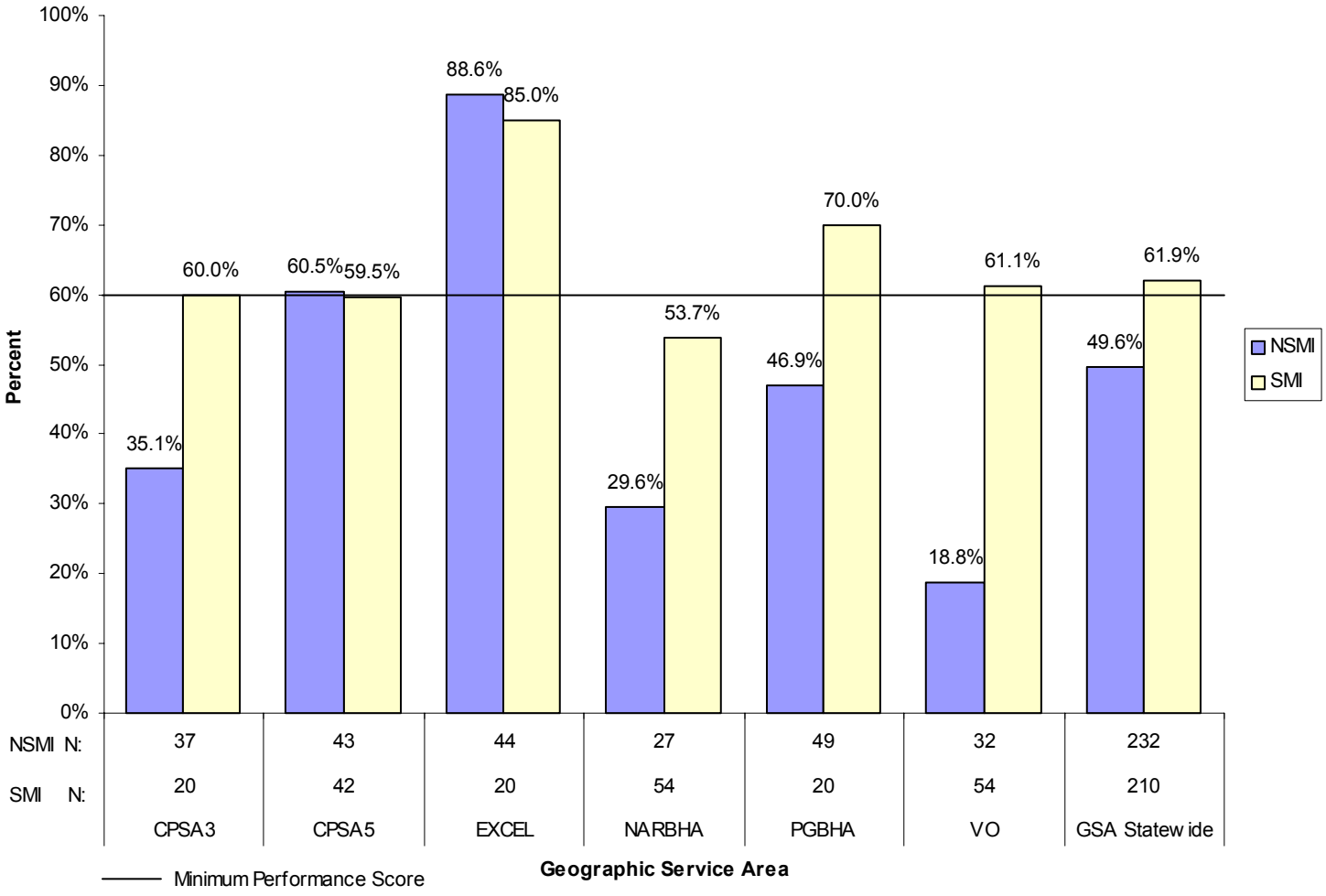
Standard 15a

Behavioral health care has been communicated or attempts have been made to coordinate with the PCP in the following circumstances:

a. Initial assessment and treatment recommendations

Standard 15b

Figure B-26—ADHS Independent Case Review 2002: Standard 15b



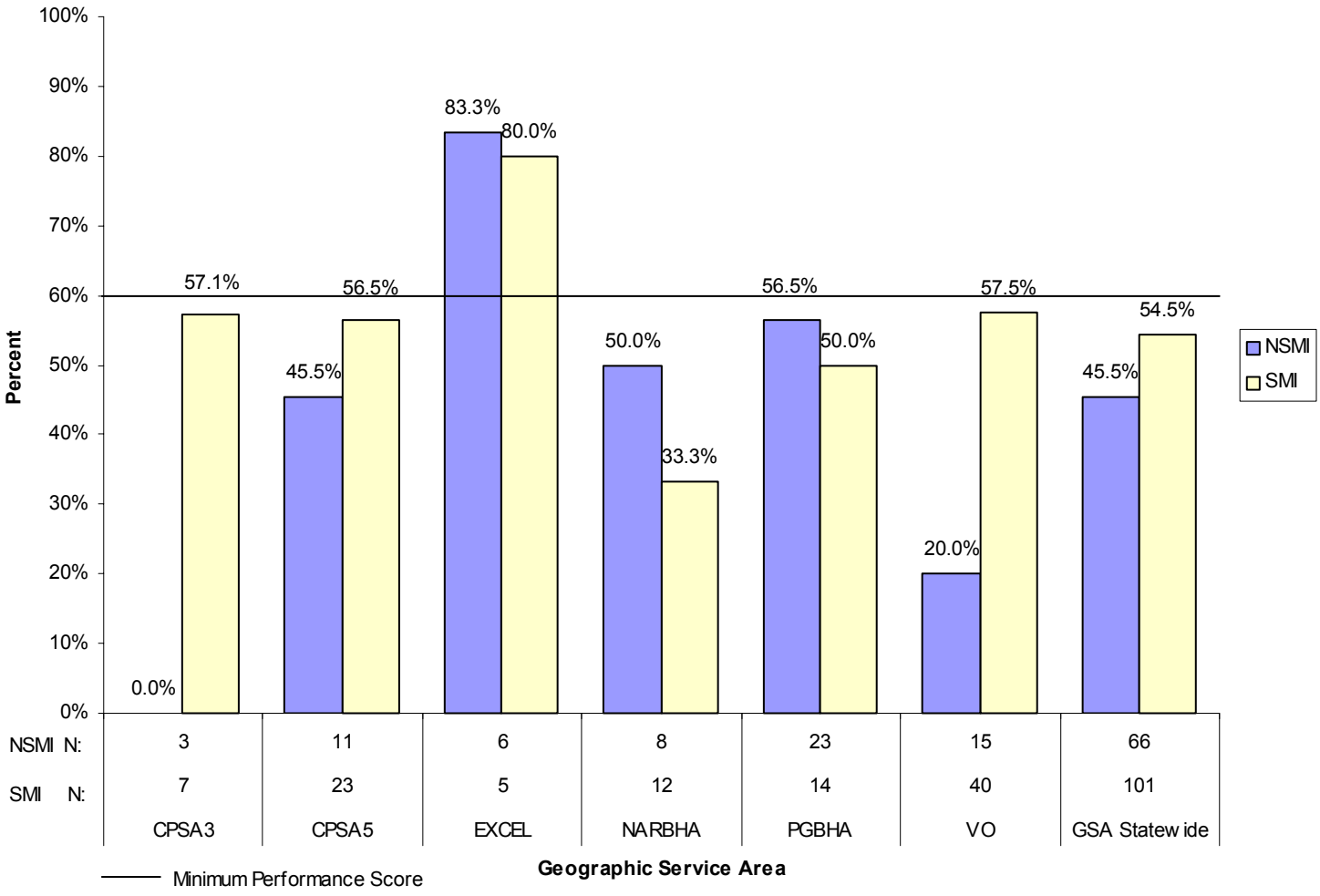
Standard 15b

Behavioral health care has been communicated or attempts have been made to coordinate with the PCP in the following circumstances:

b. Initiation and significant changes in psychotropic medications and significant adverse reactions

Standard 15c

Figure B-27—ADHS Independent Case Review 2002: Standard 15c

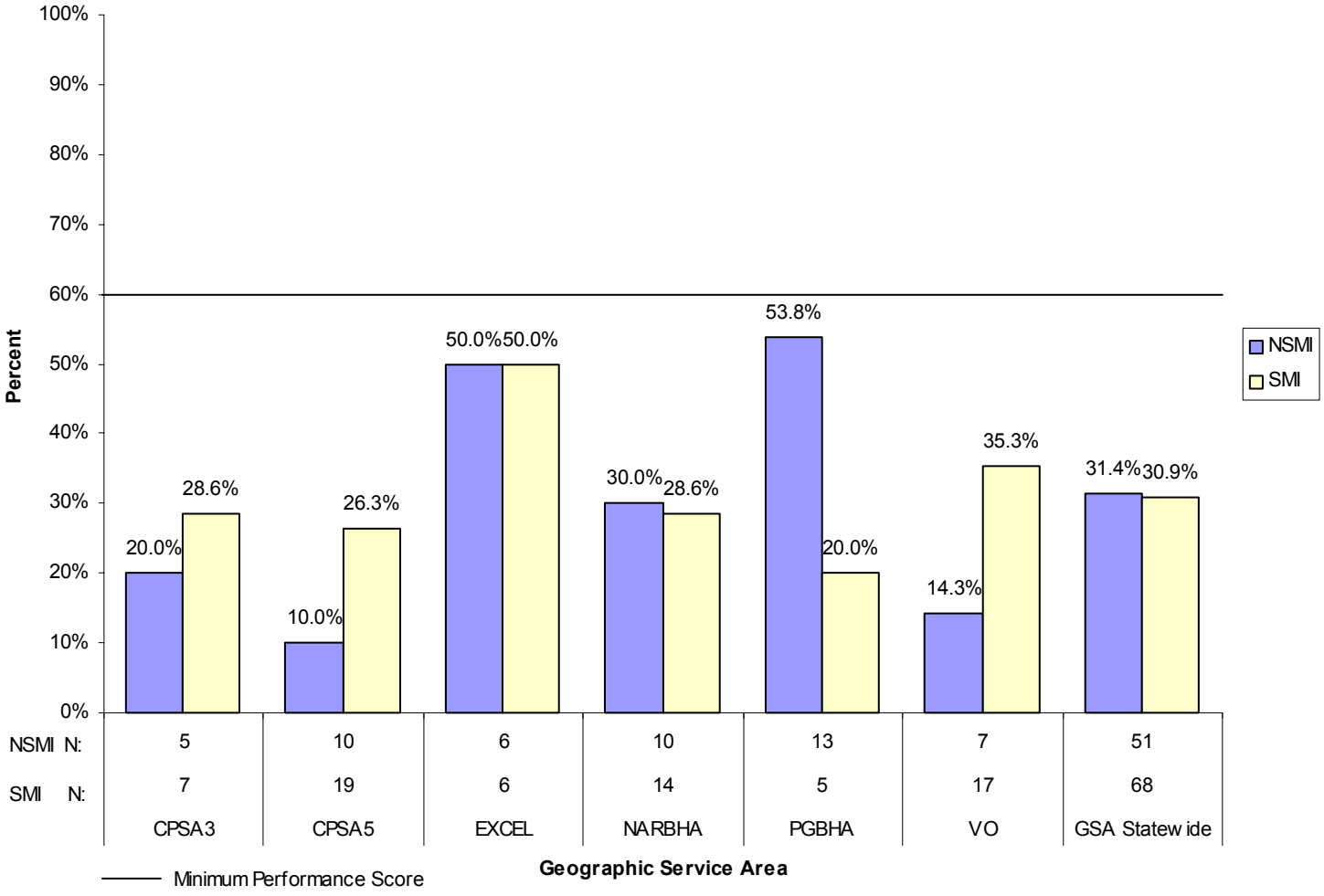


Standard 15c Behavioral health care has been communicated or attempts have been made to coordinate with the PCP in the following circumstances:

c. Results of relevant laboratory, radiology, and other tests

Standard 15d

Figure B-28—ADHS Independent Case Review 2002: Standard 15d



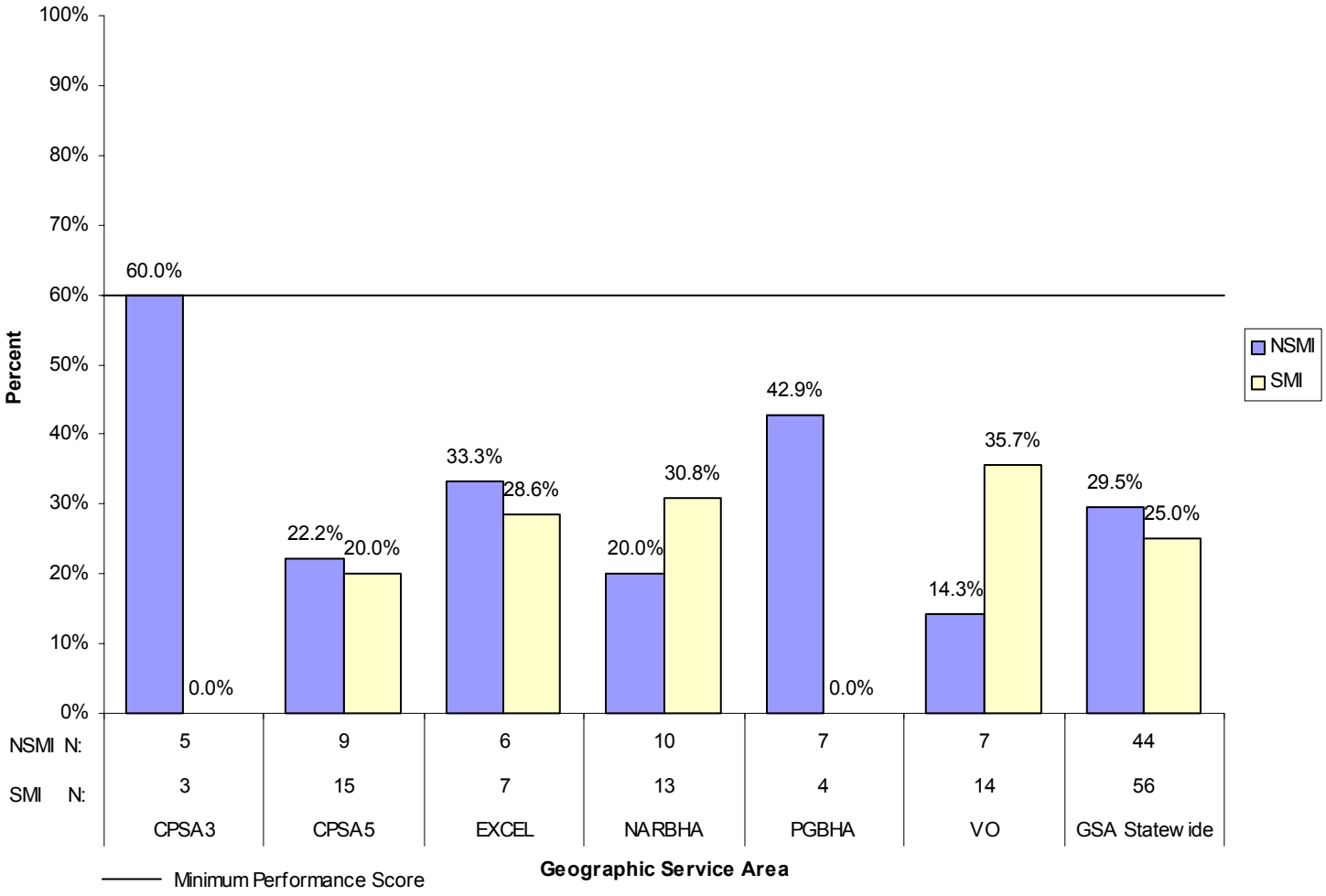
Standard 15d

Behavioral health care has been communicated or attempts have been made to coordinate with the PCP in the following circumstances:

d. Emergency/crisis admission or events

Standard 15e

Figure B-29—ADHS Independent Case Review 2002: Standard 15e

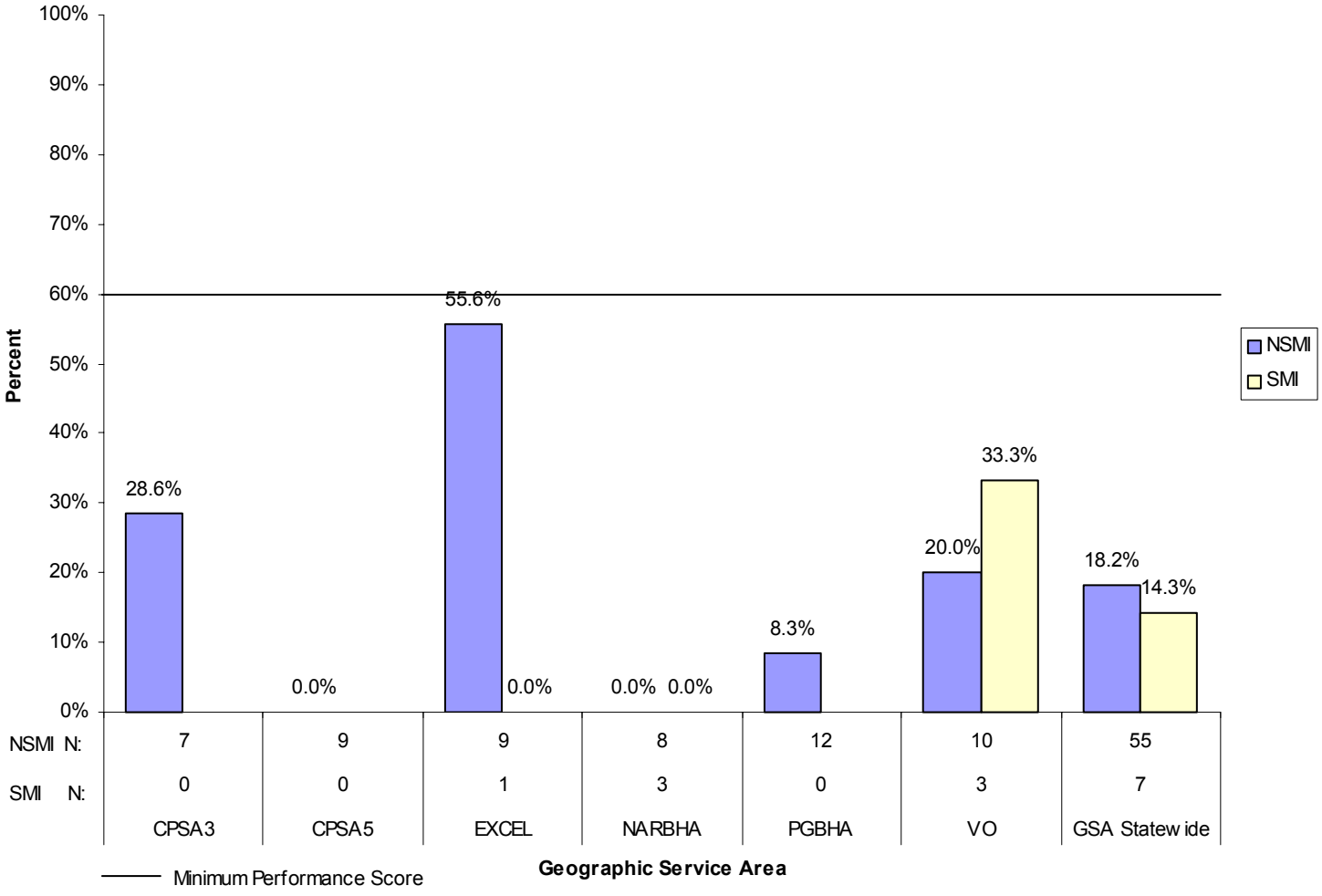


Standard 15e Behavioral health care has been communicated or attempts have been made to coordinate with the PCP in the following circumstances:

e. Discharge from an inpatient setting

Standard 15f

Figure B-30—ADHS Independent Case Review 2002: Standard 15f

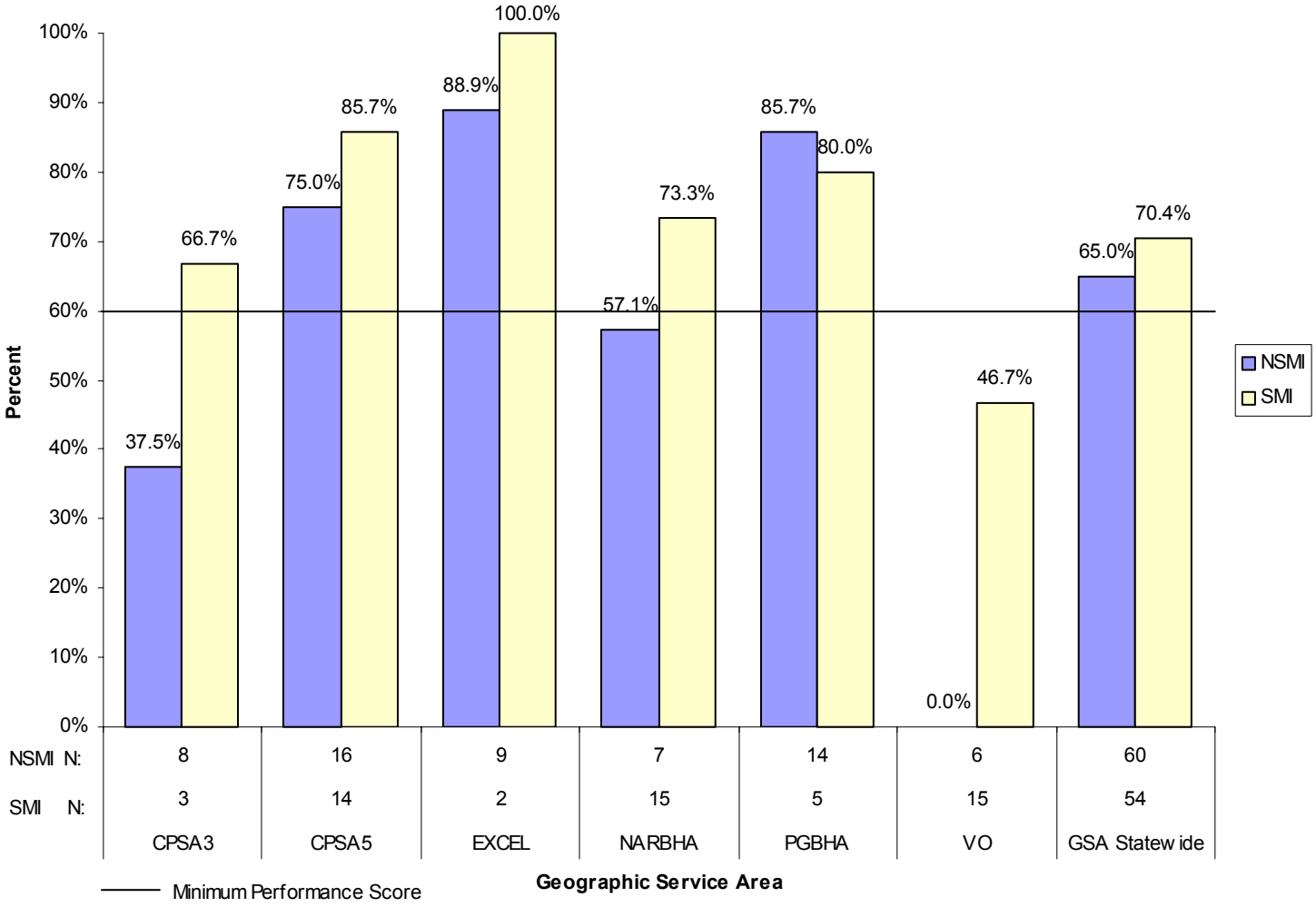


Standard 15f Behavioral health care has been communicated or attempts have been made to coordinate with the PCP in the following circumstances:

f. Disenrollment from ADHS/RBHA

Standard 15g

Figure B-31—ADHS Independent Case Review 2002: Standard 15g



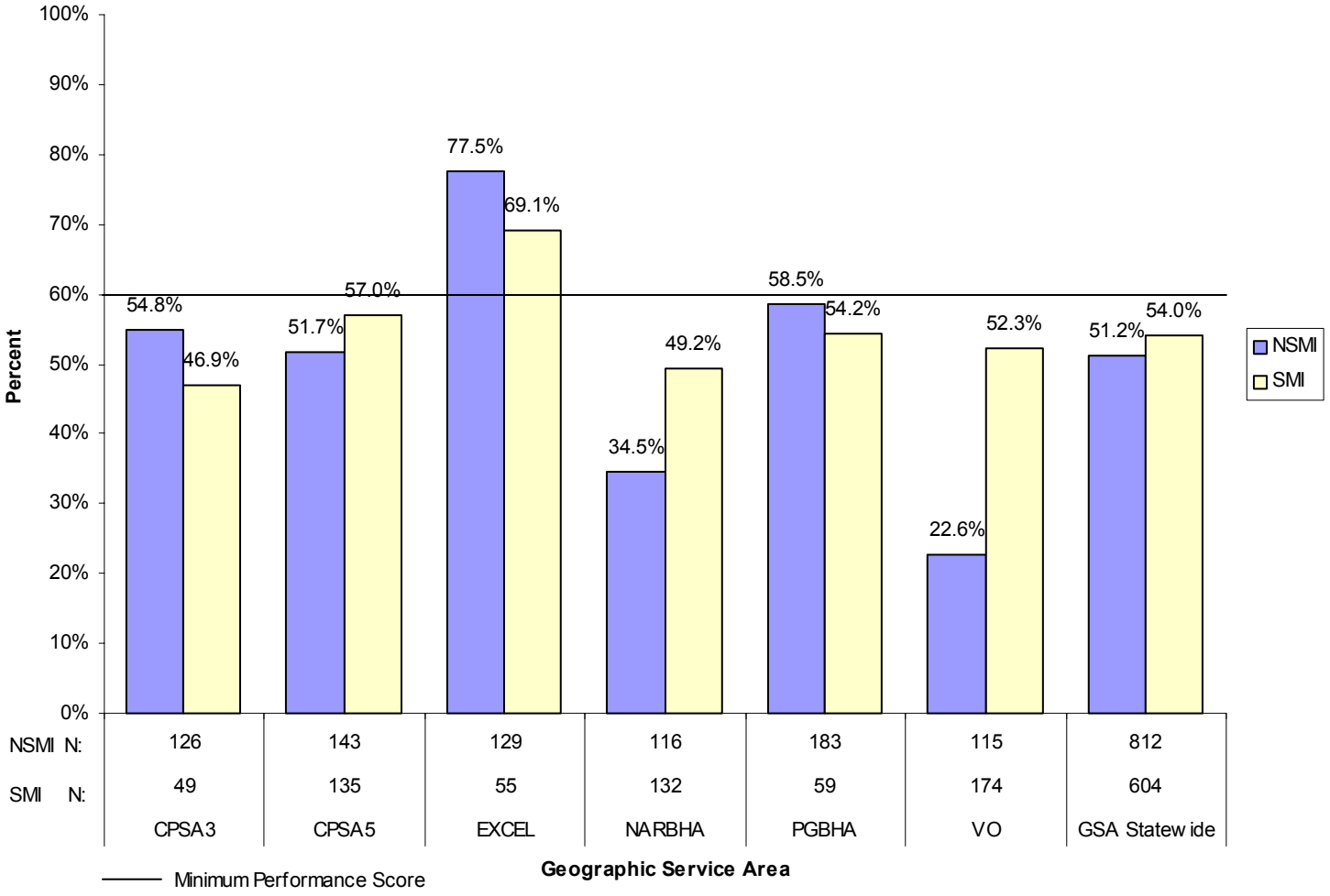
Standard 15g

Behavioral health care has been communicated or attempts have been made to coordinate with the PCP in the following circumstances:

g. Any other events requiring medical consultation with the individual's PCP

Standard 15a–g

Figure B-32—ADHS Independent Case Review 2002: Standard 15a–g



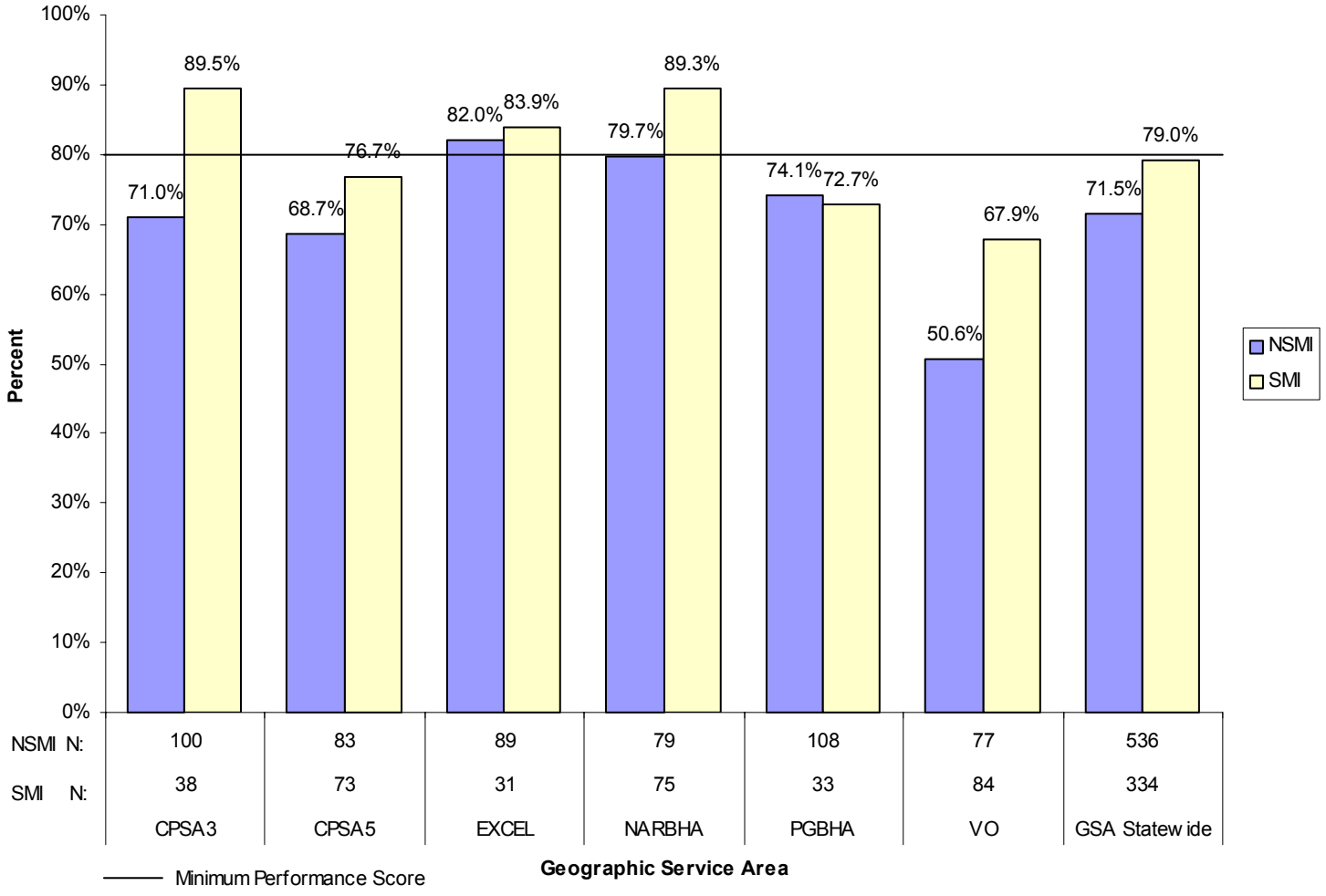
Standard 15a–g

Behavioral health care has been communicated or attempts have been made to coordinate with the PCP in the following circumstances:

a. Initial assessment and treatment recommendations
b. Initiation and significant changes in psychotropic medications and significant adverse reactions
c. Results of relevant laboratory, radiology, and other tests
d. Emergency/crisis admission or events
e. Discharge from an inpatient setting
f. Disenrollment from ADHS/RBHA
g. Any other events requiring medical consultation with the individual's PCP

Standard 16

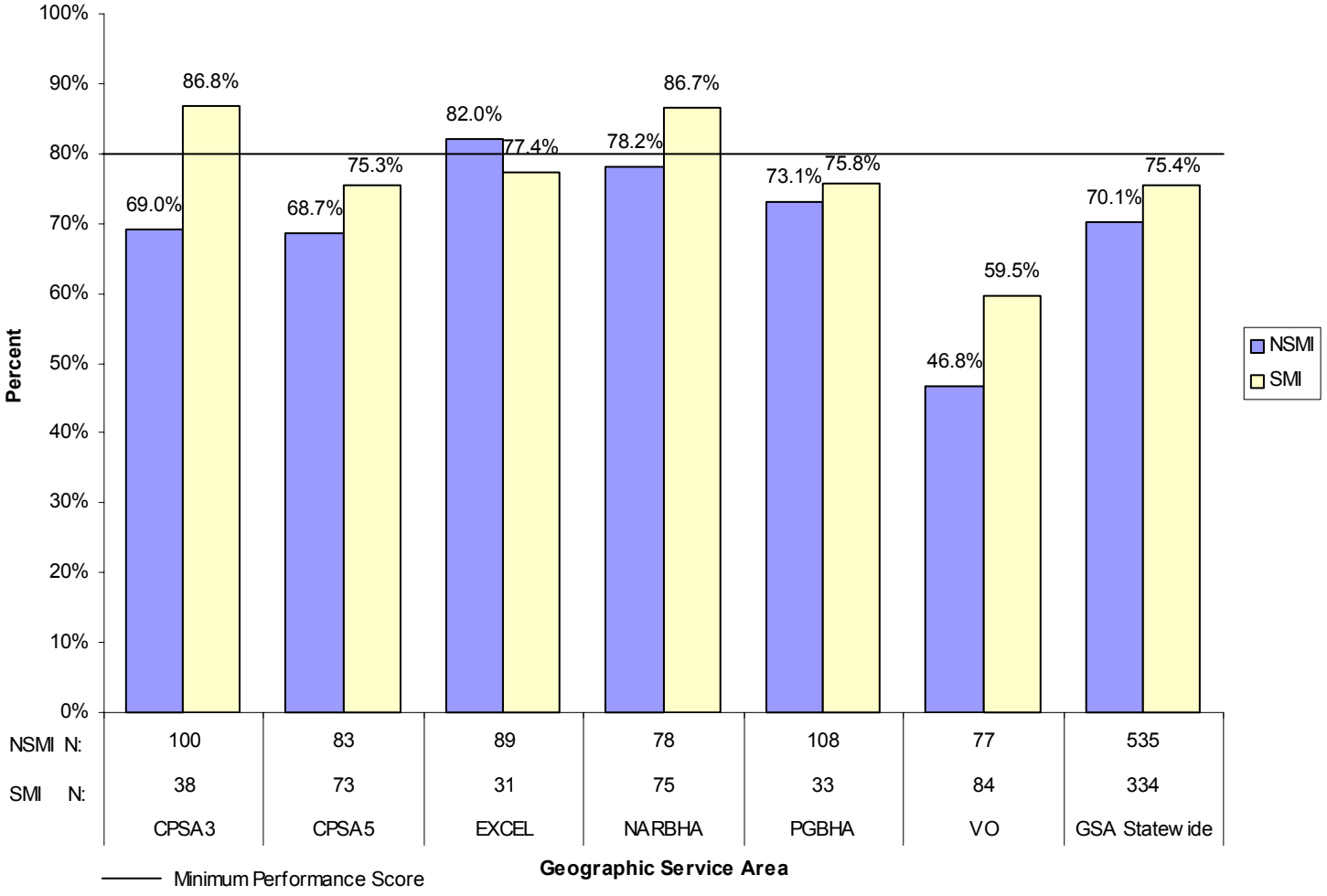
Figure B-33—ADHS Independent Case Review 2002: Standard 16



Standard 16 | There is evidence of symptomatic improvement.

Standard 17

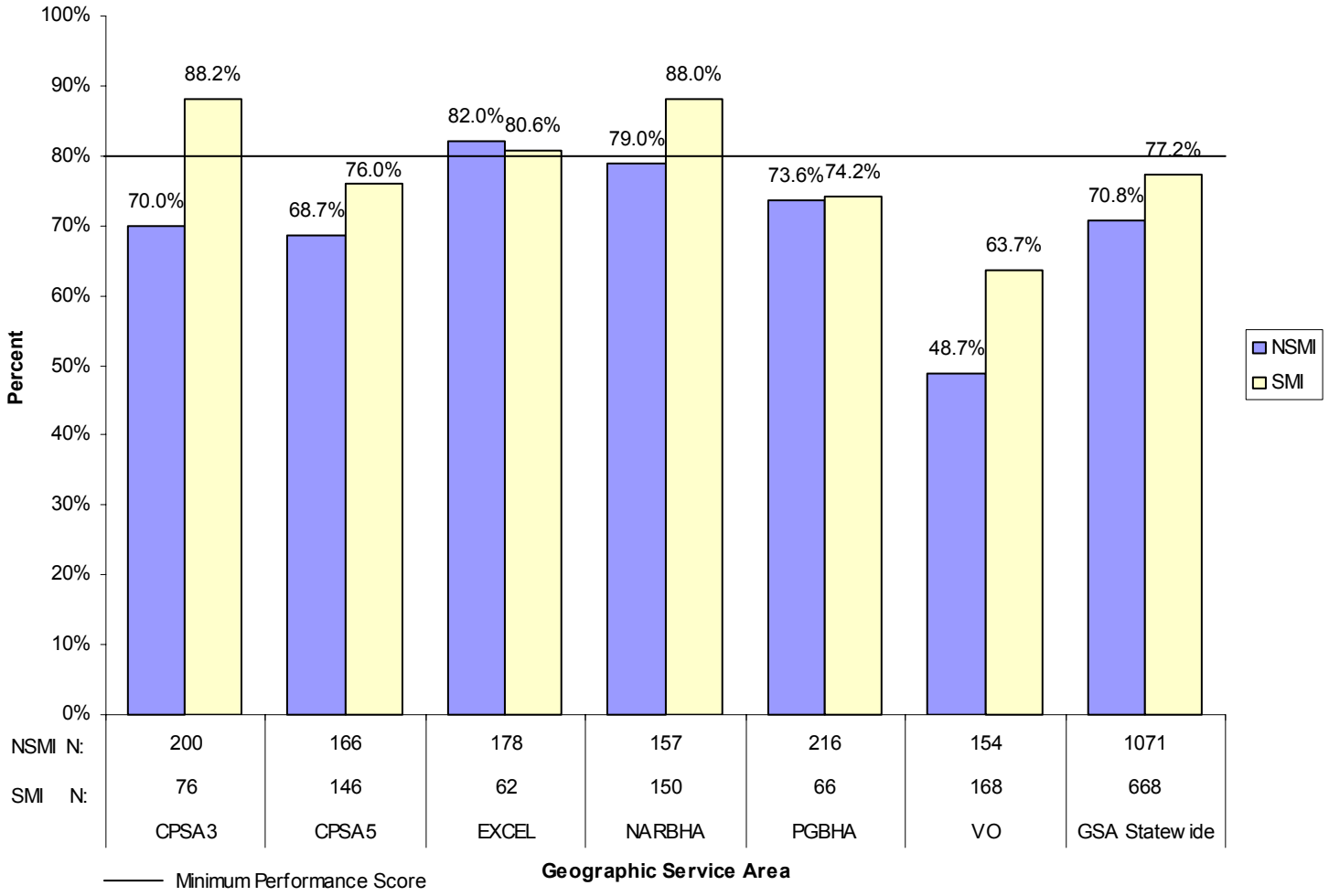
Figure B-34—ADHS Independent Case Review 2002: Standard 17



Standard 17 | There is evidence of functional improvement.

Standards 16 and 17

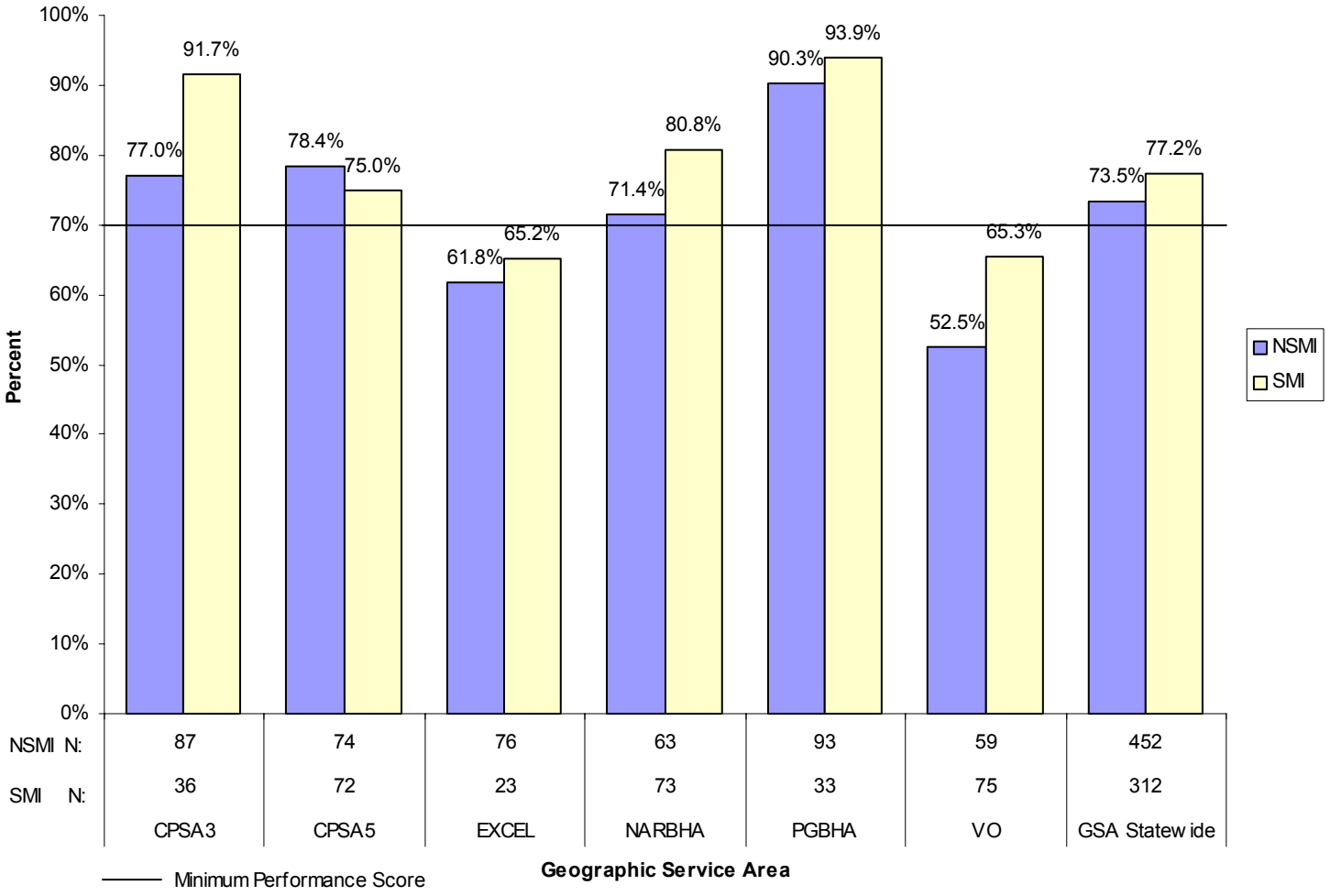
Figure B-35—ADHS Independent Case Review 2002: Standards 16 and 17



Standards 16 & 17 | This chart is the roll-up of Standards 16 and 17.

Standard 18

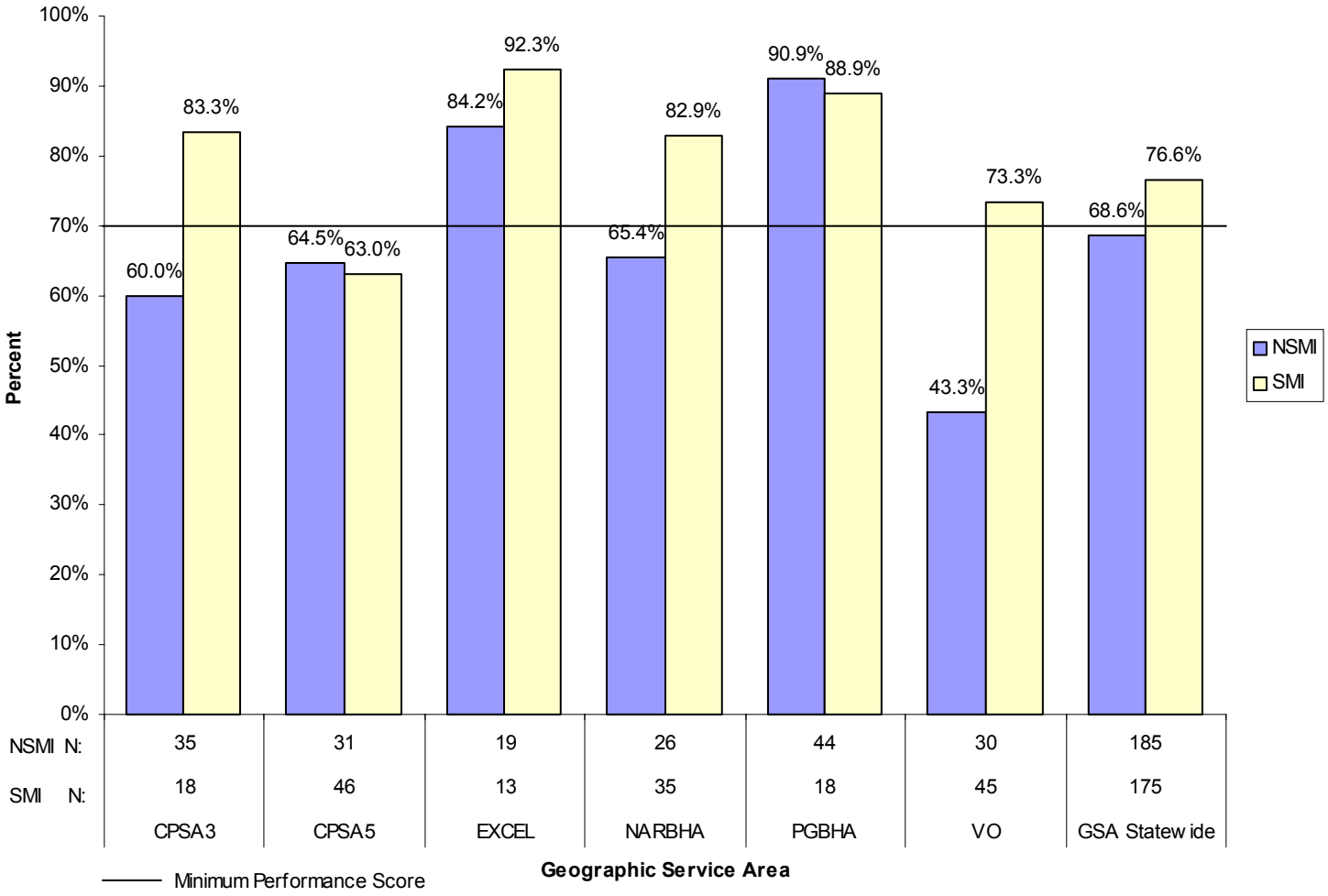
Figure B-36—ADHS Independent Case Review 2002: Standard 18



Standard 18	Service plans and/or services are revised based on progress or lack of progress in the individual's behavioral health condition.

Standard 19

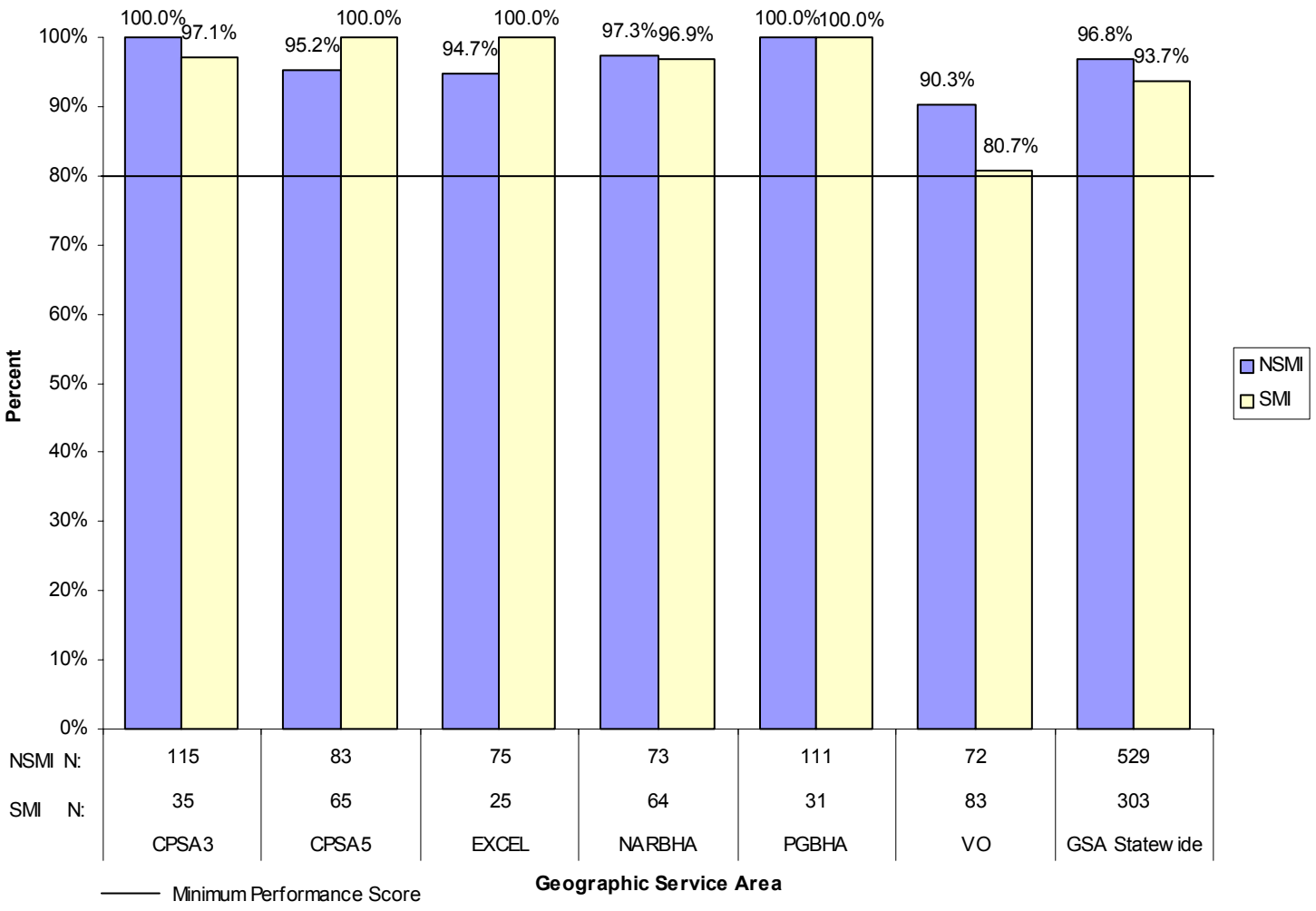
Figure B-37—ADHS Independent Case Review 2002: Standard 19



Standard 19 Service plans and/or services are revised based on significant changes in the individual's behavioral health condition.

Standard 20a

Figure B-38—ADHS Independent Case Review 2002: Standard 20a

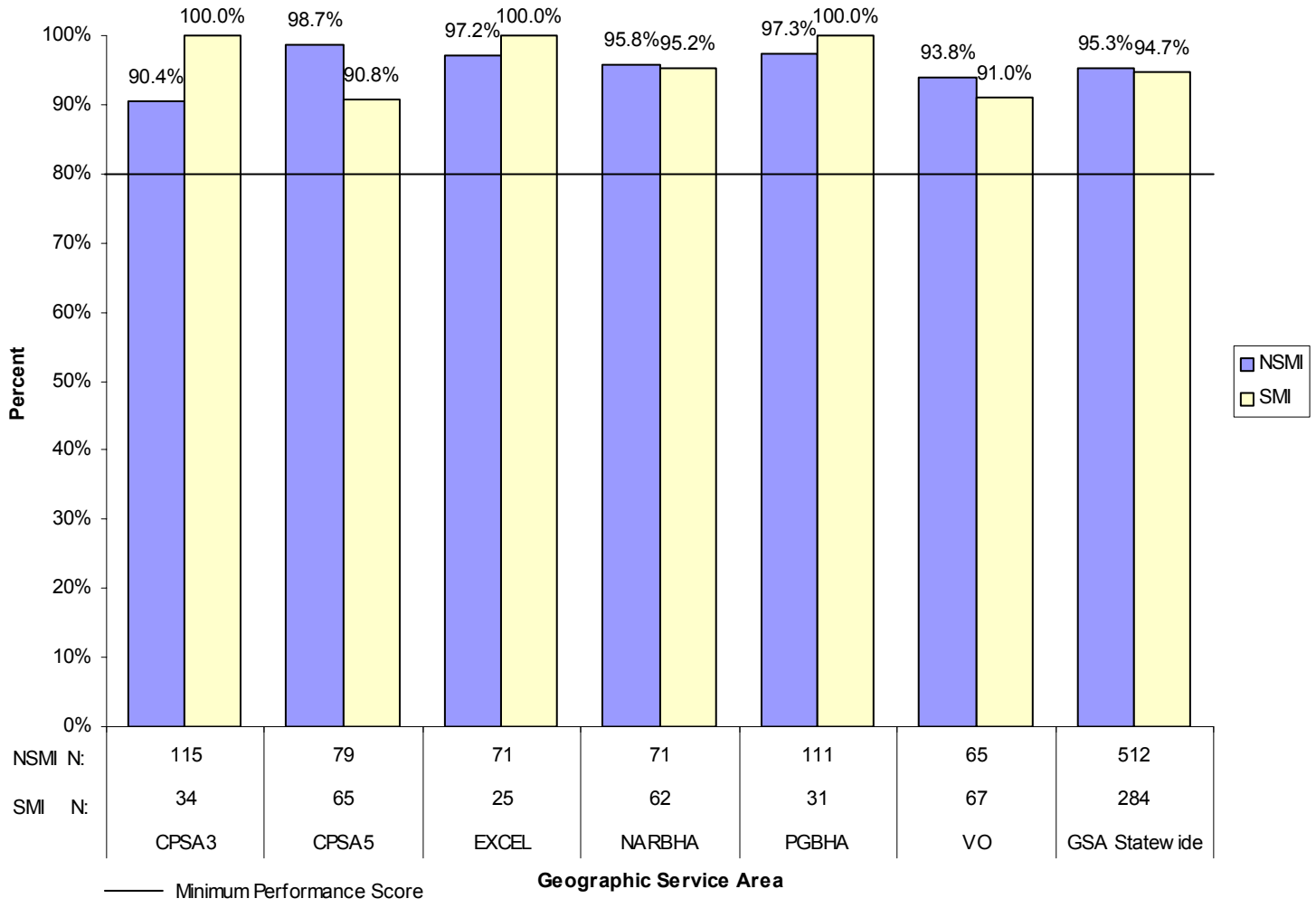


Standard 20a The treatment plan:

a. Incorporates the identified needs of the individual

Standard 20b

Figure B-39—ADHS Independent Case Review 2002: Standard 20b



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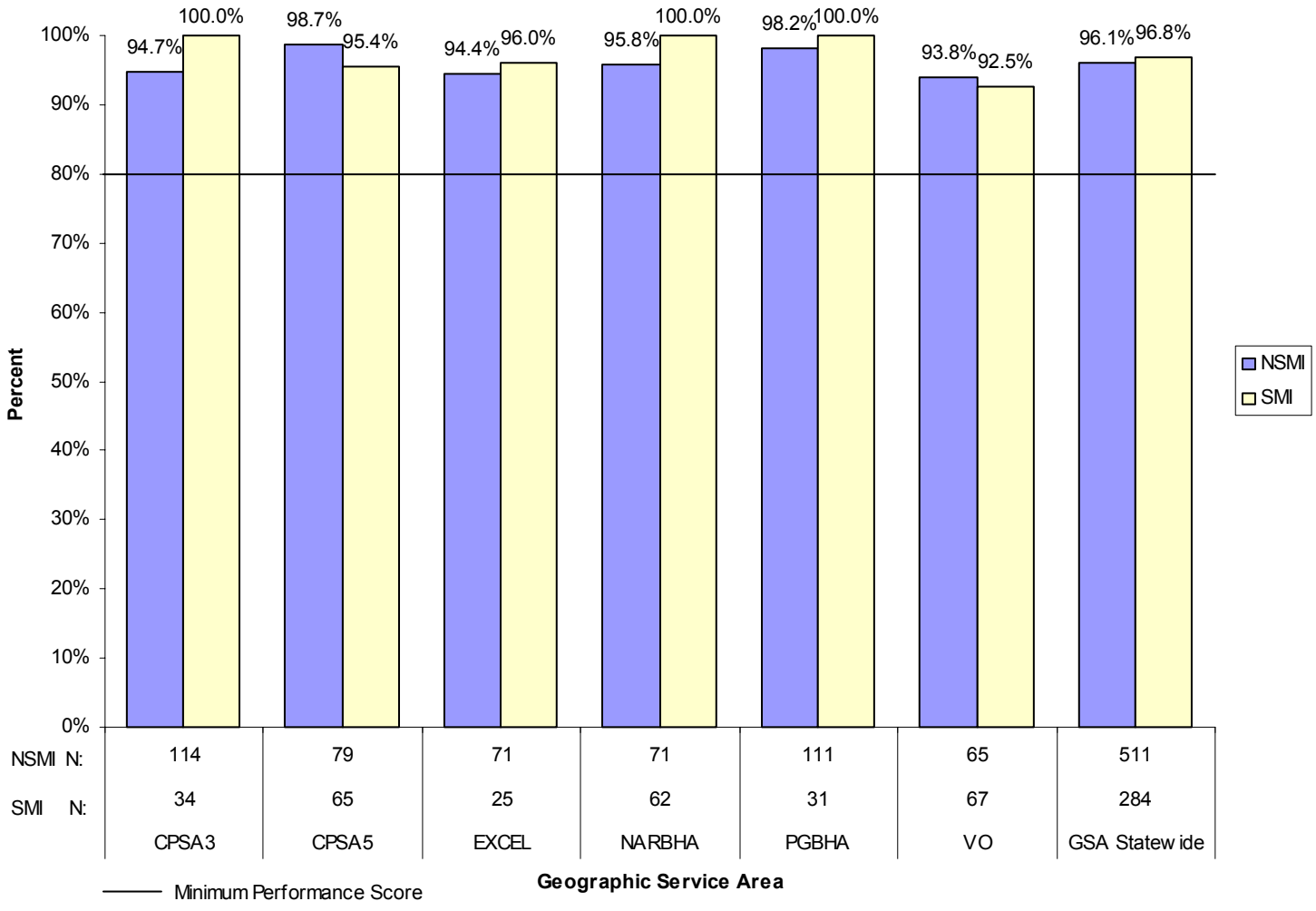
Standard 20b

The treatment plan:

b. Includes measurable goals which address those needs

Standard 20c

Figure B-40—ADHS Independent Case Review 2002: Standard 20c



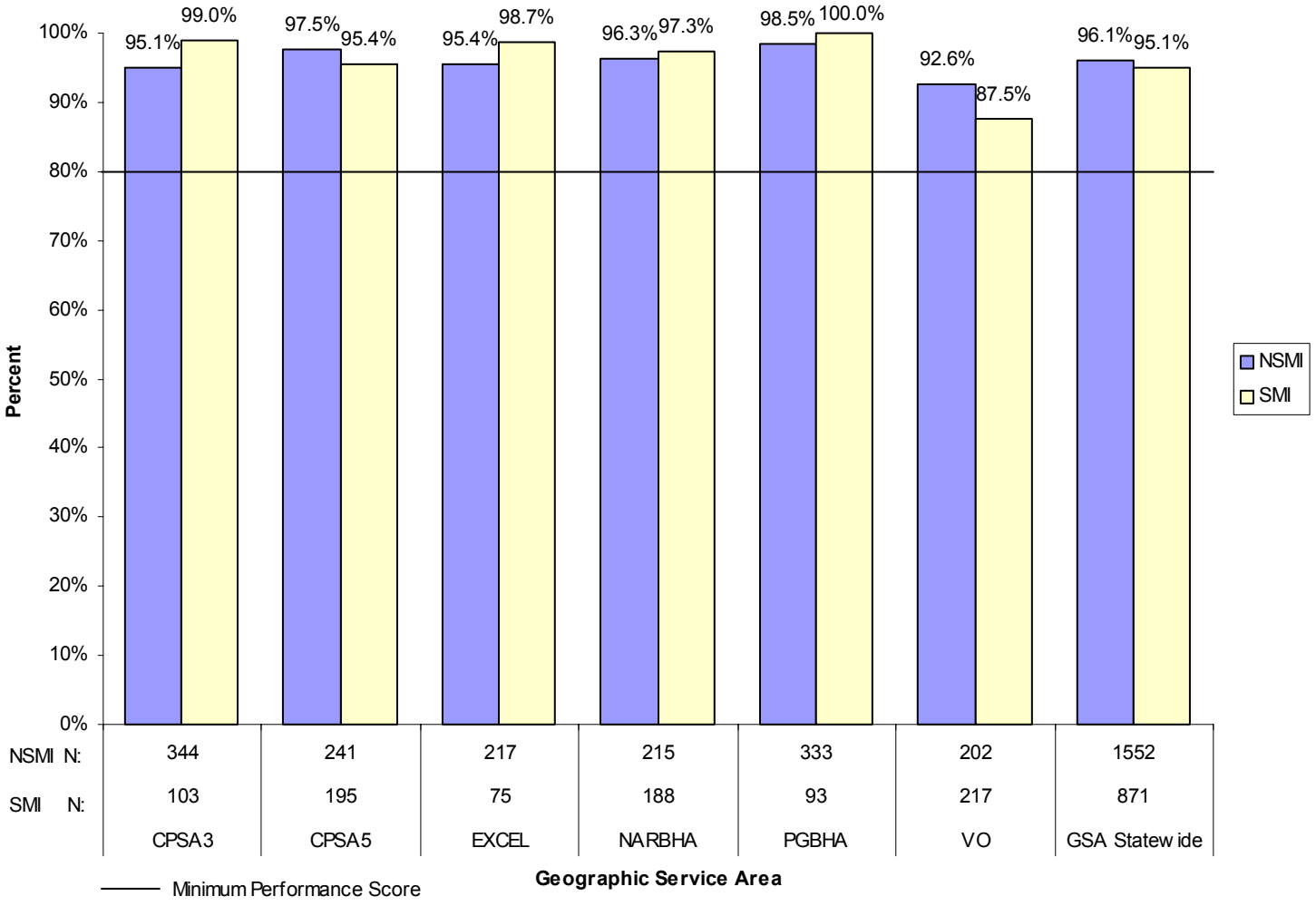
Standard 20c

The treatment plan:

c. Describes specific action steps to reasonably accomplish the goals

Standard 20a–c

Figure B-41—ADHS Independent Case Review 2002: Standard 20a–c



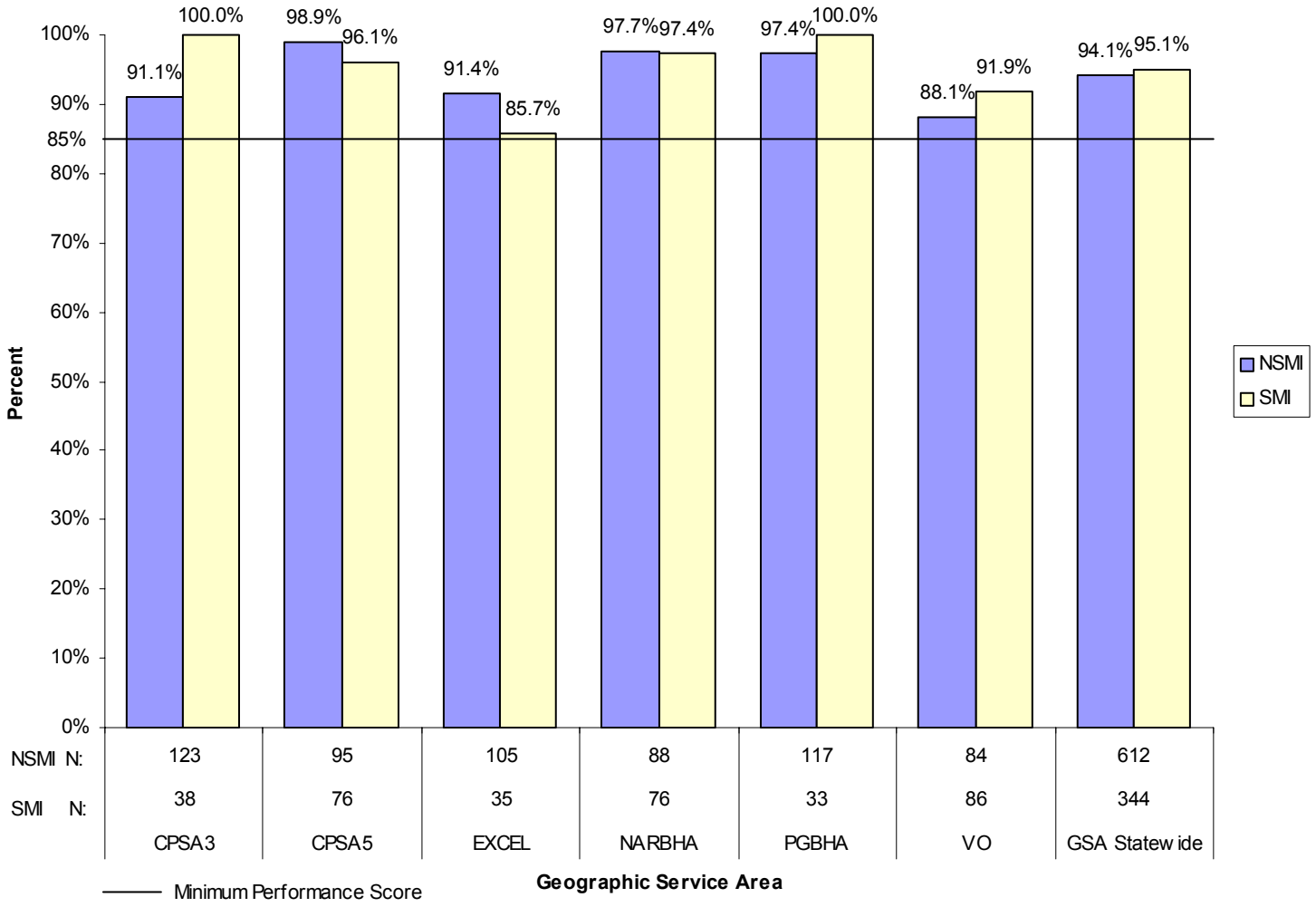
Standard 20a–c

The treatment plan:

a. Incorporates the identified needs of the individual
b. Includes measurable goals which address those needs
c. Describes specific action steps to reasonably accomplish the goals

Standard 21

Figure B-42—ADHS Independent Case Review 2002: Standard 21



Standard 21 | Services are provided in a timeframe responsive to the urgency of the member's need.

APPENDIX C. Distribution of Responses by GSA

Appendix C contains tables that present the distribution of responses by GSA for adults, children, and adult SMI and non-SMI.

Figure C-1—ADHS Independent Case Review 2002: CPSA-3 Adult

CPSA-3 Adult	YES		NO		NA	
	N	%	N	%	N	%
Standard 1	152	94.41	9	5.59	0	0
2	150	93.17	11	6.83	0	0
3a	158	98.14	3	1.86	0	0
3b	18	11.18	30	18.63	113	70.19
3c	60	37.27	8	4.97	93	57.76
4	152	94.41	9	5.59	0	0
5a	13	8.07	0	0	148	91.93
5b	0	0	0	0	161	100.00
5c	68	42.50	44	27.50	48	30.00
5d	17	10.56	3	1.86	141	87.58
5e	10	6.21	4	2.48	147	91.30
5f	2	1.24	0	0	159	98.76
6	4	50.00	1	12.50	3	37.50
7	160	99.38	1	0.62	0	0
8	151	93.79	9	5.59	1	0.62
9	8	4.97	153	95.03	0	0
10	31	19.25	52	32.30	78	48.45
11	31	19.25	22	13.66	108	67.08
12	32	19.88	7	4.35	122	75.78
13	55	34.16	39	24.22	67	41.61
14	5	3.11	2	1.24	154	95.65
15a	50	31.06	20	12.42	91	56.52
15b	25	15.53	32	19.88	104	64.60
15c	4	2.48	6	3.73	151	93.79
15d	3	1.86	9	5.59	149	92.55
15e	3	1.86	5	3.11	153	95.03
15f	2	1.24	5	3.11	154	95.65
15g	5	3.11	6	3.73	150	93.17
16	105	65.22	33	20.50	23	14.29
17	102	63.35	36	22.36	23	14.29
18	100	62.11	23	14.29	38	23.60
19	36	22.36	17	10.56	108	67.08
20a	149	92.55	1	0.62	11	6.83
20b	138	85.71	11	6.83	12	7.45
20c	142	88.20	6	3.73	13	8.07
21	150	93.17	11	6.83	0	0

Figure C-2—ADHS Independent Case Review 2002: CPSA-3 Child

CPSA-3 Child	YES		NO		NA	
	N	%	N	%	N	%
Standard						
1	82	93.18	6	6.82	0	0
2	84	95.45	4	4.55	0	0
3a	79	89.77	9	10.23	0	0
3b	84	95.45	3	3.41	1	1.14
3c	46	52.27	6	6.82	36	40.91
4	87	98.86	1	1.14	0	0
5a	2	2.27	0	0	86	97.73
5b	1	1.14	0	0	87	98.86
5c	43	48.86	25	28.41	20	22.73
5d	4	4.55	1	1.14	83	94.32
5e	10	11.36	2	2.27	76	86.36
5f	4	4.55	1	1.14	83	94.32
6	4	66.67	1	16.67	1	16.67
7	88	100.00	0	0	0	0
8	88	100.00	0	0	0	0
9	4	4.55	84	95.45	0	0
10	14	15.91	22	25.00	52	59.09
11	5	5.68	4	4.55	79	89.77
12	9	10.23	2	2.27	77	87.50
13	30	34.09	15	17.05	43	48.86
14	6	6.82	1	1.14	81	92.05
15a	36	40.91	15	17.05	37	42.05
15b	6	6.82	16	18.18	66	75.00
15c	2	2.27	1	1.14	85	96.59
15d	0	0	2	2.27	86	97.73
15e	0	0	1	1.14	87	98.86
15f	5	5.68	5	5.68	78	88.64
15g	2	2.27	1	1.14	85	96.59
16	67	76.14	15	17.05	6	6.82
17	68	77.27	14	15.91	6	6.82
18	67	76.14	8	9.09	13	14.77
19	22	25.00	3	3.41	63	71.59
20a	84	95.45	1	1.14	3	3.41
20b	79	89.77	5	5.68	4	4.55
20c	80	90.91	4	4.55	4	4.55
21	83	94.32	5	5.68	0	0

Figure C-3—ADHS Independent Case Review 2002: CPSA-5 Adult

CPSA-5 Adult	YES		NO		NA	
	N	%	N	%	N	%
Standard 1	144	84.21	27	15.79	0	0
2	159	92.98	12	7.02	0	0
3a	168	98.25	3	1.75	0	0
3b	32	18.71	21	12.28	118	69.01
3c	71	41.52	7	4.09	93	54.39
4	162	94.74	9	5.26	0	0
5a	29	16.96	0	0	142	83.04
5b	8	4.68	0	0	163	95.32
5c	72	42.11	29	16.96	70	40.94
5d	35	20.47	0	0	136	79.53
5e	14	8.19	4	2.34	153	89.47
5f	7	4.09	0	0	164	95.91
6	10	90.91	0	0	1	9.09
7	168	98.25	3	1.75	0	0
8	164	95.91	4	2.34	3	1.75
9	19	11.11	152	88.89	0	0
10	38	22.22	77	45.03	56	32.75
11	30	17.54	44	25.73	97	56.73
12	46	26.90	9	5.26	116	67.84
13	84	49.12	52	30.41	35	20.47
14	7	4.09	2	1.17	162	94.74
15a	47	27.49	20	11.70	104	60.82
15b	51	29.82	34	19.88	86	50.29
15c	18	10.53	16	9.36	137	80.12
15d	6	3.51	23	13.45	142	83.04
15e	5	2.92	19	11.11	147	85.96
15f	0	0	9	5.26	162	94.74
15g	24	14.04	6	3.51	141	82.46
16	113	66.08	43	25.15	15	8.77
17	112	65.50	44	25.73	15	8.77
18	112	65.50	34	19.88	25	14.62
19	49	28.65	28	16.37	94	54.97
20a	144	84.21	4	2.34	23	13.45
20b	137	80.12	7	4.09	27	15.79
20c	140	81.87	4	2.34	27	15.79
21	167	97.66	4	2.34	0	0

Figure C-4—ADHS Independent Case Review 2002: CPSA-5 Child

CPSA-5 Child	YES		NO		NA	
	N	%	N	%	N	%
Standard 1	65	70.65	27	29.35	0	0
2	81	88.04	11	11.96	0	0
3a	73	79.35	19	20.65	0	0
3b	80	86.96	6	6.52	6	6.52
3c	55	59.78	10	10.87	27	29.35
4	88	95.65	4	4.35	0	0
5a	2	2.17	1	1.09	89	96.74
5b	0	0	0	0	92	100.00
5c	33	35.87	20	21.74	39	42.39
5d	5	5.43	0	0	87	94.57
5e	7	7.61	3	3.26	82	89.13
5f	4	4.35	0	0	88	95.65
6	20	86.96	0	0	3	13.04
7	91	98.91	1	1.09	0	0
8	89	96.74	2	2.17	1	1.09
9	12	13.04	80	86.96	0	0
10	27	29.35	23	25.00	42	45.65
11	3	3.26	11	11.96	78	84.78
12	15	16.30	1	1.09	76	82.61
13	39	42.39	16	17.39	37	40.22
14	3	3.26	0	0	89	96.74
15a	23	25.00	9	9.78	60	65.22
15b	8	8.70	18	19.57	66	71.74
15c	2	2.17	1	1.09	89	96.74
15d	0	0	3	3.26	89	96.74
15e	0	0	2	2.17	90	97.83
15f	0	0	5	5.43	87	94.57
15g	7	7.61	0	0	85	92.39
16	65	70.65	18	19.57	9	9.78
17	64	69.57	20	21.74	8	8.70
18	67	72.83	15	16.30	10	10.87
19	14	15.22	8	8.70	70	76.09
20a	77	83.70	5	5.43	10	10.87
20b	75	81.52	1	1.09	16	17.39
20c	74	80.43	2	2.17	16	17.39
21	88	95.65	4	4.35	0	0

Figure C-5—ADHS Independent Case Review 2002: EXCEL Adult

EXCEL Adult	YES		NO		NA	
	N	%	N	%	N	%
Standard						
1	118	84.29	22	15.71	0	0
2	119	85.00	21	15.00	0	0
3a	134	95.71	6	4.29	0	0
3b	33	23.57	25	17.86	82	58.57
3c	53	37.86	6	4.29	81	57.86
4	123	87.86	17	12.14	0	0
5a	16	11.43	1	0.71	123	87.86
5b	2	1.43	1	0.71	137	97.86
5c	44	31.43	28	20.00	68	48.57
5d	16	11.43	3	2.14	121	86.43
5e	5	3.57	7	5.00	128	91.43
5f	3	2.14	1	0.71	136	97.14
6	6	75.00	1	12.50	1	12.50
7	133	95.00	7	5.00	0	0
8	122	87.14	10	7.14	8	5.71
9	42	30.00	98	70.00	0	0
10	39	27.86	44	31.43	57	40.71
11	20	14.29	20	14.29	100	71.43
12	23	16.43	4	2.86	113	80.71
13	62	44.29	27	19.29	51	36.43
14	14	10.00	3	2.14	123	87.86
15a	48	34.29	15	10.71	77	55.00
15b	56	40.00	8	5.71	76	54.29
15c	9	6.43	2	1.43	129	92.14
15d	6	4.29	6	4.29	128	91.43
15e	4	2.86	9	6.43	127	90.71
15f	5	3.57	5	3.57	130	92.86
15g	10	7.14	1	0.71	129	92.14
16	99	70.71	21	15.00	20	14.29
17	97	69.29	23	16.43	20	14.29
18	62	44.29	37	26.43	41	29.29
19	28	20.00	4	2.86	108	77.14
20a	96	68.57	4	2.86	40	28.57
20b	94	67.14	2	1.43	44	31.43
20c	91	65.00	5	3.57	44	31.43
21	126	90.00	14	10.00	0	0

Figure C-6—ADHS Independent Case Review 2002: EXCEL Child

EXCEL Child	YES		NO		NA	
	N	%	N	%	N	%
Standard 1	90	85.71	15	14.29	0	0
2	92	87.62	13	12.38	0	0
3a	85	80.95	20	19.05	0	0
3b	93	88.57	9	8.57	3	2.86
3c	47	44.76	13	12.38	45	42.86
4	97	92.38	8	7.62	0	0
5a	5	4.76	2	1.90	98	93.33
5b	2	1.90	0	0	103	98.10
5c	29	27.62	17	16.19	59	56.19
5d	4	3.81	1	0.95	100	95.24
5e	9	8.57	4	3.81	92	87.62
5f	3	2.86	1	0.95	101	96.19
6	4	66.67	0	0	2	33.33
7	102	97.14	3	2.86	0	0
8	96	91.43	5	4.76	4	3.81
9	30	28.57	75	71.43	0	0
10	14	13.33	32	30.48	59	56.19
11	10	9.52	6	5.71	89	84.76
12	9	8.57	1	0.95	95	90.48
13	26	24.76	23	21.90	56	53.33
14	8	7.62	2	1.90	95	90.48
15a	45	42.86	8	7.62	52	49.52
15b	39	37.14	4	3.81	62	59.05
15c	4	3.81	4	3.81	97	92.38
15d	1	0.95	3	2.86	101	96.19
15e	1	0.95	2	1.90	102	97.14
15f	4	3.81	6	5.71	95	90.48
15g	4	3.81	0	0	101	96.19
16	69	65.71	14	13.33	22	20.95
17	73	69.52	13	12.38	19	18.10
18	55	52.38	20	19.05	30	28.57
19	20	19.05	4	3.81	81	77.14
20a	81	77.14	5	4.76	19	18.10
20b	75	71.43	6	5.71	24	22.86
20c	74	70.48	7	6.67	24	22.86
21	98	93.33	7	6.67	0	0

Figure C-7—ADHS Independent Case Review 2002: NARBHA Adult

NARBHA Adult	YES		NO		NA	
	N	%	N	%	N	%
Standard						
1	140	85.37	24	14.63	0	0
2	153	93.29	11	6.71	0	0
3a	160	97.56	4	2.44	0	0
3b	37	22.56	24	14.63	103	62.80
3c	58	35.37	4	2.44	102	62.20
4	158	96.34	6	3.66	0	0
5a	25	15.24	1	0.61	138	84.15
5b	6	3.66	0	0	158	96.34
5c	98	59.76	21	12.80	45	27.44
5d	32	19.51	0	0	132	80.49
5e	12	7.32	2	1.22	150	91.46
5f	9	5.49	1	0.61	154	93.90
6	7	77.78	1	11.11	1	11.11
7	164	100.00	0	0	0	0
8	162	98.78	2	1.22	0	0
9	45	27.44	119	72.56	0	0
10	72	43.90	37	22.56	55	33.54
11	30	18.29	18	10.98	116	70.73
12	43	26.22	4	2.44	117	71.34
13	79	48.17	38	23.17	47	28.66
14	5	3.05	1	0.61	158	96.34
15a	32	19.51	35	21.34	97	59.15
15b	37	22.56	44	26.83	83	50.61
15c	8	4.88	12	7.32	144	87.80
15d	7	4.27	17	10.37	140	85.37
15e	6	3.66	17	10.37	141	85.98
15f	0	0	11	6.71	153	93.29
15g	15	9.15	7	4.27	142	86.59
16	130	79.27	24	14.63	10	6.10
17	126	76.83	27	16.46	11	6.71
18	104	63.41	32	19.51	28	17.07
19	46	28.05	15	9.15	103	62.80
20a	133	81.10	4	2.44	27	16.46
20b	127	77.44	6	3.66	31	18.90
20c	130	79.27	3	1.83	31	18.90
21	160	97.56	4	2.44	0	0

Figure C-8—ADHS Independent Case Review 2002: NARBHA Child

NARBHA Child	YES		NO		NA	
	N	%	N	%	N	%
Standard						
1	80	85.11	14	14.89	0	0
2	87	92.55	7	7.45	0	0
3a	83	88.30	11	11.70	0	0
3b	87	92.55	5	5.32	2	2.13
3c	53	56.38	2	2.13	39	41.49
4	90	95.74	4	4.26	0	0
5a	1	1.06	0	0	93	98.94
5b	0	0	0	0	94	100.00
5c	44	46.81	13	13.83	37	39.36
5d	4	4.26	0	0	90	95.74
5e	5	5.32	2	2.13	87	92.55
5f	0	0	0	0	94	100.00
6	16	100.00	0	0	0	0
7	92	97.87	2	2.13	0	0
8	89	94.68	2	2.13	3	3.19
9	17	18.09	77	81.91	0	0
10	32	34.04	18	19.15	44	46.81
11	13	13.83	3	3.19	78	82.98
12	12	12.77	1	1.06	81	86.17
13	38	40.43	13	13.83	43	45.74
14	2	2.13	0	0	92	97.87
15a	19	20.21	25	26.60	50	53.19
15b	19	20.21	17	18.09	58	61.70
15c	4	4.26	7	7.45	83	88.30
15d	0	0	2	2.13	92	97.87
15e	1	1.06	0	0	93	98.94
15f	1	1.06	4	4.26	89	94.68
15g	11	11.70	4	4.26	79	84.04
16	69	73.40	17	18.09	8	8.51
17	66	70.21	20	21.28	8	8.51
18	60	64.52	17	18.28	16	17.20
19	28	29.79	12	12.77	54	57.45
20a	78	82.98	5	5.32	11	11.70
20b	74	78.72	4	4.26	16	17.02
20c	75	79.79	3	3.19	16	17.02
21	91	96.81	3	3.19	0	0

Figure C-9—ADHS Independent Case Review 2002: PGBHA Adult

PGBHA Adult	YES		NO		NA	
	N	%	N	%	N	%
Standard 1	136	90.67	14	9.33	0	0
2	144	96.00	6	4.00	0	0
3a	145	96.67	5	3.33	0	0
3b	34	22.67	31	20.67	85	56.67
3c	58	38.67	6	4.00	86	57.33
4	149	99.33	1	0.67	0	0
5a	13	8.67	0	0	137	91.33
5b	4	2.67	0	0	146	97.33
5c	84	56.00	18	12.00	48	32.00
5d	20	13.33	0	0	130	86.67
5e	7	4.67	6	4.00	137	91.33
5f	6	4.00	0	0	144	96.00
6	7	87.50	0	0	1	12.50
7	149	99.33	1	0.67	0	0
8	149	99.33	0	0	1	0.67
9	41	27.33	109	72.67	0	0
10	81	54.00	29	19.33	40	26.67
11	31	20.67	19	12.67	100	66.67
12	31	20.67	9	6.00	110	73.33
13	62	41.33	49	32.67	39	26.00
14	5	3.33	3	2.00	142	94.67
15a	54	36.00	22	14.67	74	49.33
15b	37	24.67	32	21.33	81	54.00
15c	20	13.33	17	11.33	113	75.33
15d	8	5.33	10	6.67	132	88.00
15e	3	2.00	8	5.33	139	92.67
15f	1	0.67	11	7.33	138	92.00
15g	16	10.67	3	2.00	131	87.33
16	104	69.33	37	24.67	9	6.00
17	104	69.33	37	24.67	9	6.00
18	115	76.67	11	7.33	24	16.00
19	56	37.33	6	4.00	88	58.67
20a	142	94.67	0	0	8	5.33
20b	139	92.67	3	2.00	8	5.33
20c	140	93.33	2	1.33	8	5.33
21	147	98.00	3	2.00	0	0

Figure C-10—ADHS Independent Case Review 2002: PGBHA Child

PGBHA Child	YES		NO		NA	
	N	%	N	%	N	%
Standard 1	81	88.04	11	11.96	0	0
2	86	93.48	6	6.52	0	0
3a	84	91.30	8	8.70	0	0
3b	84	91.30	6	6.52	2	2.17
3c	49	53.26	4	4.35	39	42.39
4	91	98.91	1	1.09	0	0
5a	4	4.35	2	2.17	86	93.48
5b	2	2.17	1	1.09	89	96.74
5c	34	36.96	10	10.87	48	52.17
5d	8	8.70	2	2.17	82	89.13
5e	5	5.43	3	3.26	84	91.30
5f	7	7.61	3	3.26	82	89.13
6	4	66.67	0	0	2	33.33
7	90	97.83	2	2.17	0	0
8	89	96.74	1	1.09	2	2.17
9	23	25.00	69	75.00	0	0
10	33	35.87	18	19.57	41	44.57
11	8	8.70	7	7.61	77	83.70
12	12	13.04	2	2.17	78	84.78
13	40	43.48	14	15.22	38	41.30
14	2	2.17	2	2.17	88	95.65
15a	29	31.52	15	16.30	48	52.17
15b	10	10.87	22	23.91	60	65.22
15c	4	4.35	3	3.26	85	92.39
15d	1	1.09	7	7.61	84	91.30
15e	0	0	4	4.35	88	95.65
15f	0	0	6	6.52	86	93.48
15g	1	1.09	2	2.17	89	96.74
16	73	79.35	13	14.13	6	6.52
17	71	77.17	16	17.39	5	5.43
18	74	80.43	8	8.70	10	10.87
19	35	38.04	6	6.52	51	55.43
20a	88	95.65	1	1.09	3	3.26
20b	81	88.04	7	7.61	4	4.35
20c	82	89.13	6	6.52	4	4.35
21	88	95.65	4	4.35	0	0

Figure C-11—ADHS Independent Case Review 2002: ValueOptions Adult

VO Adult	YES		NO		NA	
	N	%	N	%	N	%
Standard 1	152	89.41	18	10.59	0	0
2	142	83.53	28	16.47	0	0
3a	152	89.94	17	10.06	0	0
3b	33	19.41	69	40.59	68	40.00
3c	71	42.01	21	12.43	77	45.56
4	141	84.94	25	15.06	0	0
5a	20	11.76	5	2.94	145	85.29
5b	5	2.96	6	3.55	158	93.49
5c	88	52.07	30	17.75	51	30.18
5d	18	10.65	10	5.92	141	83.43
5e	20	11.76	15	8.82	135	79.41
5f	15	8.82	7	4.12	148	87.06
6	4	28.57	5	35.71	5	35.71
7	155	91.18	15	8.82	0	0
8	146	86.39	7	4.14	16	9.47
9	20	11.83	149	88.17	0	0
10	81	47.65	62	36.47	27	15.88
11	66	38.82	25	14.71	79	46.47
12	36	21.18	13	7.65	121	71.18
13	90	52.94	47	27.65	33	19.41
14	4	2.35	7	4.12	159	93.53
15a	29	17.06	40	23.53	101	59.41
15b	39	22.94	47	27.65	84	49.41
15c	26	15.29	29	17.06	115	67.65
15d	7	4.12	17	10.00	146	85.88
15e	6	3.53	15	8.82	149	87.65
15f	3	1.76	10	5.88	157	92.35
15g	7	4.14	14	8.28	148	87.57
16	96	56.47	65	38.24	9	5.29
17	86	50.59	75	44.12	9	5.29
18	80	47.06	54	31.76	36	21.18
19	46	27.06	29	17.06	95	55.88
20a	132	77.65	23	13.53	15	8.82
20b	122	71.76	10	5.88	38	22.35
20c	123	72.35	9	5.29	38	22.35
21	153	90.00	17	10.00	0	0

Figure C-12—ADHS Independent Case Review 2002: ValueOptions Child

VO Child	YES		NO		NA	
	N	%	N	%	N	%
Standard						
1	89	89.00	11	11.00	0	0
2	93	93.00	7	7.00	0	0
3a	78	78.00	22	22.00	0	0
3b	89	89.00	8	8.00	3	3.00
3c	71	71.00	14	14.00	15	15.00
4	95	95.00	5	5.00	0	0
5a	4	4.00	0	0	96	96.00
5b	0	0	0	0	100	100.00
5c	36	36.00	8	8.00	56	56.00
5d	8	8.00	0	0	92	92.00
5e	3	3.00	0	0	97	97.00
5f	2	2.00	0	0	98	98.00
6	54	84.38	1	1.56	9	14.06
7	97	97.00	3	3.00	0	0
8	96	96.00	1	1.00	3	3.00
9	16	16.00	84	84.00	0	0
10	44	44.00	29	29.00	27	27.00
11	38	38.00	16	16.00	46	46.00
12	20	20.00	2	2.00	78	78.00
13	48	48.00	24	24.00	28	28.00
14	1	1.00	1	1.00	98	98.00
15a	21	21.00	11	11.00	68	68.00
15b	11	11.00	11	11.00	78	78.00
15c	7	7.00	6	6.00	87	87.00
15d	1	1.00	4	4.00	95	95.00
15e	2	2.00	3	3.00	95	95.00
15f	1	1.00	2	2.00	97	97.00
15g	7	7.00	3	3.00	90	90.00
16	76	76.00	6	6.00	18	18.00
17	77	77.00	8	8.00	15	15.00
18	57	57.00	19	19.00	24	24.00
19	21	21.00	7	7.00	72	72.00
20a	77	77.00	2	2.00	21	21.00
20b	77	77.00	0	0	23	23.00
20c	77	77.00	0	0	23	23.00
21	98	98.99	1	1.01	0	0

Figure C-13—ADHS Independent Case Review 2002: CPSA-3 Adult SMI

CPSA-3 Adult SMI	YES		NO		NA	
	N	%	N	%	N	%
Standard						
1	37	97.37	1	2.63	0	0
2	38	100.00	0	0	0	0
3a	37	97.37	1	2.63	0	0
3b	9	23.68	7	18.42	22	57.89
3c	14	36.84	0	0	24	63.16
4	38	100.00	0	0	0	0
5a	6	15.79	0	0	32	84.21
5b	0	0	0	0	38	100.00
5c	15	39.47	1	2.63	22	57.89
5d	9	23.68	0	0	29	76.32
5e	0	0	0	0	38	100.00
5f	1	2.63	0	0	37	97.37
6	2	66.67	0	0	1	33.33
7	38	100.00	0	0	0	0
8	38	100.00	0	0	0	0
9	3	7.89	35	92.11	0	0
10	8	21.05	20	52.63	10	26.32
11	16	42.11	10	26.32	12	31.58
12	12	31.58	3	7.89	23	60.53
13	18	47.37	20	52.63	0	0
14	1	2.63	1	2.63	36	94.74
15a	3	7.89	6	15.79	29	76.32
15b	12	31.58	8	21.05	18	47.37
15c	4	10.53	3	7.89	31	81.58
15d	2	5.26	5	13.16	31	81.58
15e	0	0	3	7.89	35	92.11
15f	0	0	0	0	38	100.00
15g	2	5.26	1	2.63	35	92.11
16	34	89.47	4	10.53	0	0
17	33	86.84	5	13.16	0	0
18	33	86.84	3	7.89	2	5.26
19	15	39.47	3	7.89	20	52.63
20a	34	89.47	1	2.63	3	7.89
20b	34	89.47	0	0	4	10.53
20c	34	89.47	0	0	4	10.53
21	38	100.00	0	0	0	0

Figure C-14—ADHS Independent Case Review 2002: CPSA-3 Adult Non-SMI

CPSA-3 Adult NSMI	YES		NO		NA	
	N	%	N	%	N	%
Standard 1	115	93.50	8	6.50	0	0
2	112	91.06	11	8.94	0	0
3a	121	98.37	2	1.63	0	0
3b	9	7.32	23	18.70	91	73.98
3c	46	37.40	8	6.50	69	56.10
4	114	92.68	9	7.32	0	0
5a	7	5.69	0	0	116	94.31
5b	0	0	0	0	123	100.00
5c	53	43.44	43	35.25	26	21.31
5d	8	6.50	3	2.44	112	91.06
5e	10	8.13	4	3.25	109	88.62
5f	1	0.81	0	0	122	99.19
6	2	40.00	1	20.00	2	40.00
7	122	99.19	1	0.81	0	0
8	113	91.87	9	7.32	1	0.81
9	5	4.07	118	95.93	0	0
10	23	18.70	32	26.02	68	55.28
11	15	12.20	12	9.76	96	78.05
12	20	16.26	4	3.25	99	80.49
13	37	30.08	19	15.45	67	54.47
14	4	3.25	1	0.81	118	95.93
15a	47	38.21	14	11.38	62	50.41
15b	13	10.57	24	19.51	86	69.92
15c	0	0	3	2.44	120	97.56
15d	1	0.81	4	3.25	118	95.93
15e	3	2.44	2	1.63	118	95.93
15f	2	1.63	5	4.07	116	94.31
15g	3	2.44	5	4.07	115	93.50
16	71	57.72	29	23.58	23	18.70
17	69	56.10	31	25.20	23	18.70
18	67	54.47	20	16.26	36	29.27
19	21	17.07	14	11.38	88	71.54
20a	115	93.50	0	0	8	6.50
20b	104	84.55	11	8.94	8	6.50
20c	108	87.80	6	4.88	9	7.32
21	112	91.06	11	8.94	0	0

Figure C-15—ADHS Independent Case Review 2002: CPSA-5 Adult SMI

CPSA-5 Adult SMI	YES		NO		NA	
	N	%	N	%	N	%
Standard						
1	62	81.58	14	18.42	0	0
2	70	92.11	6	7.89	0	0
3a	75	98.68	1	1.32	0	0
3b	19	25.00	12	15.79	45	59.21
3c	30	39.47	3	3.95	43	56.58
4	72	94.74	4	5.26	0	0
5a	19	25.00	0	0	57	75.00
5b	4	5.26	0	0	72	94.74
5c	40	52.63	13	17.11	23	30.26
5d	23	30.26	0	0	53	69.74
5e	9	11.84	1	1.32	66	86.84
5f	6	7.89	0	0	70	92.11
6	0	0	0	0	1	100.00
7	75	98.68	1	1.32	0	0
8	72	94.74	3	3.95	1	1.32
9	5	6.58	71	93.42	0	0
10	22	28.95	38	50.00	16	21.05
11	19	25.00	32	42.11	25	32.89
12	30	39.47	6	7.89	40	52.63
13	44	57.89	30	39.47	2	2.63
14	3	3.95	0	0	73	96.05
15a	19	25.00	3	3.95	54	71.05
15b	25	32.89	17	22.37	34	44.74
15c	13	17.11	10	13.16	53	69.74
15d	5	6.58	14	18.42	57	75.00
15e	3	3.95	12	15.79	61	80.26
15f	0	0	0	0	76	100.00
15g	12	15.79	2	2.63	62	81.58
16	56	73.68	17	22.37	3	3.95
17	55	72.37	18	23.68	3	3.95
18	54	71.05	18	23.68	4	5.26
19	29	38.16	17	22.37	30	39.47
20a	65	85.53	0	0	11	14.47
20b	59	77.63	6	7.89	11	14.47
20c	62	81.58	3	3.95	11	14.47
21	73	96.05	3	3.95	0	0

Figure C-16—ADHS Independent Case Review 2002: CPSA-5 Adult Non-SMI

CPSA-5 Adult NSMI	YES		NO		NA	
	N	%	N	%	N	%
Standard						
1	82	86.32	13	13.68	0	0
2	89	93.68	6	6.32	0	0
3a	93	97.89	2	2.11	0	0
3b	13	13.68	9	9.47	73	76.84
3c	41	43.16	4	4.21	50	52.63
4	90	94.74	5	5.26	0	0
5a	10	10.53	0	0	85	89.47
5b	4	4.21	0	0	91	95.79
5c	32	33.68	16	16.84	47	49.47
5d	12	12.63	0	0	83	87.37
5e	5	5.26	3	3.16	87	91.58
5f	1	1.05	0	0	94	98.95
6	10	100.00	0	0	0	0
7	93	97.89	2	2.11	0	0
8	92	96.84	1	1.05	2	2.11
9	14	14.74	81	85.26	0	0
10	16	16.84	39	41.05	40	42.11
11	11	11.58	12	12.63	72	75.79
12	16	16.84	3	3.16	76	80.00
13	40	42.11	22	23.16	33	34.74
14	4	4.21	2	2.11	89	93.68
15a	28	29.47	17	17.89	50	52.63
15b	26	27.37	17	17.89	52	54.74
15c	5	5.26	6	6.32	84	88.42
15d	1	1.05	9	9.47	85	89.47
15e	2	2.11	7	7.37	86	90.53
15f	0	0	9	9.47	86	90.53
15g	12	12.63	4	4.21	79	83.16
16	57	60.00	26	27.37	12	12.63
17	57	60.00	26	27.37	12	12.63
18	58	61.05	16	16.84	21	22.11
19	20	21.05	11	11.58	64	67.37
20a	79	83.16	4	4.21	12	12.63
20b	78	82.11	1	1.05	16	16.84
20c	78	82.11	1	1.05	16	16.84
21	94	98.95	1	1.05	0	0

Figure C-17—ADHS Independent Case Review 2002: EXCEL Adult SMI

EXCEL Adult SMI	YES		NO		NA	
	N	%	N	%	N	%
Standard 1	29	82.86	6	17.14	0	0
2	28	80.00	7	20.00	0	0
3a	32	91.43	3	8.57	0	0
3b	12	34.29	1	2.86	22	62.86
3c	10	28.57	2	5.71	23	65.71
4	29	82.86	6	17.14	0	0
5a	10	28.57	0	0	25	71.43
5b	2	5.71	0	0	33	94.29
5c	12	34.29	6	17.14	17	48.57
5d	9	25.71	0	0	26	74.29
5e	1	2.86	0	0	34	97.14
5f	2	5.71	0	0	33	94.29
6	2	66.67	1	33.33	0	0
7	31	88.57	4	11.43	0	0
8	28	80.00	3	8.57	4	11.43
9	8	22.86	27	77.14	0	0
10	10	28.57	14	40.00	11	31.43
11	10	28.57	10	28.57	15	42.86
12	7	20.00	1	2.86	27	77.14
13	15	42.86	14	40.00	6	17.14
14	1	2.86	1	2.86	33	94.29
15a	10	28.57	4	11.43	21	60.00
15b	17	48.57	3	8.57	15	42.86
15c	4	11.43	1	2.86	30	85.71
15d	3	8.57	3	8.57	29	82.86
15e	2	5.71	5	14.29	28	80.00
15f	0	0	1	2.86	34	97.14
15g	2	5.71	0	0	33	94.29
16	26	74.29	5	14.29	4	11.43
17	24	68.57	7	20.00	4	11.43
18	15	42.86	8	22.86	12	34.29
19	12	34.29	1	2.86	22	62.86
20a	25	71.43	0	0	10	28.57
20b	25	71.43	0	0	10	28.57
20c	24	68.57	1	2.86	10	28.57
21	30	85.71	5	14.29	0	0

Figure C-18—ADHS Independent Case Review 2002: EXCEL Adult Non-SMI

EXCEL Adult NSMI	YES		NO		NA	
	N	%	N	%	N	%
Standard 1	89	84.76	16	15.24	0	0
2	91	86.67	14	13.33	0	0
3a	102	97.14	3	2.86	0	0
3b	21	20.00	24	22.86	60	57.14
3c	43	40.95	4	3.81	58	55.24
4	94	89.52	11	10.48	0	0
5a	6	5.71	1	0.95	98	93.33
5b	0	0	1	0.95	104	99.05
5c	32	30.48	22	20.95	51	48.57
5d	7	6.67	3	2.86	95	90.48
5e	4	3.81	7	6.67	94	89.52
5f	1	0.95	1	0.95	103	98.10
6	4	80.00	0	0	1	20.00
7	102	97.14	3	2.86	0	0
8	94	89.52	7	6.67	4	3.81
9	34	32.38	71	67.62	0	0
10	29	27.62	30	28.57	46	43.81
11	10	9.52	10	9.52	85	80.95
12	16	15.24	3	2.86	86	81.90
13	47	44.76	13	12.38	45	42.86
14	13	12.38	2	1.90	90	85.71
15a	38	36.19	11	10.48	56	53.33
15b	39	37.14	5	4.76	61	58.10
15c	5	4.76	1	0.95	99	94.29
15d	3	2.86	3	2.86	99	94.29
15e	2	1.90	4	3.81	99	94.29
15f	5	4.76	4	3.81	96	91.43
15g	8	7.62	1	0.95	96	91.43
16	73	69.52	16	15.24	16	15.24
17	73	69.52	16	15.24	16	15.24
18	47	44.76	29	27.62	29	27.62
19	16	15.24	3	2.86	86	81.90
20a	71	67.62	4	3.81	30	28.57
20b	69	65.71	2	1.90	34	32.38
20c	67	63.81	4	3.81	34	32.38
21	96	91.43	9	8.57	0	0

Figure C-19—ADHS Independent Case Review 2002: NARBHA Adult SMI

NARBHA Adult SMI	YES		NO		NA	
	N	%	N	%	N	%
Standard						
1	62	81.58	14	18.42	0	0
2	71	93.42	5	6.58	0	0
3a	74	97.37	2	2.63	0	0
3b	17	22.37	10	13.16	49	64.47
3c	25	32.89	1	1.32	50	65.79
4	75	98.68	1	1.32	0	0
5a	15	19.74	0	0	61	80.26
5b	4	5.26	0	0	72	94.74
5c	53	69.74	7	9.21	16	21.05
5d	18	23.68	0	0	58	76.32
5e	5	6.58	0	0	71	93.42
5f	6	7.89	1	1.32	69	90.79
6	1	100.00	0	0	0	0
7	76	100.00	0	0	0	0
8	76	100.00	0	0	0	0
9	14	18.42	62	81.58	0	0
10	50	65.79	18	23.68	8	10.53
11	24	31.58	11	14.47	41	53.95
12	32	42.11	2	2.63	42	55.26
13	53	69.74	21	27.63	2	2.63
14	2	2.63	0	0	74	97.37
15a	13	17.11	8	10.53	55	72.37
15b	29	38.16	25	32.89	22	28.95
15c	4	5.26	8	10.53	64	84.21
15d	4	5.26	10	13.16	62	81.58
15e	4	5.26	9	11.84	63	82.89
15f	0	0	3	3.95	73	96.05
15g	11	14.47	4	5.26	61	80.26
16	67	88.16	8	10.53	1	1.32
17	65	85.53	10	13.16	1	1.32
18	59	77.63	14	18.42	3	3.95
19	29	38.16	6	7.89	41	53.95
20a	62	81.58	2	2.63	12	15.79
20b	59	77.63	3	3.95	14	18.42
20c	62	81.58	0	0	14	18.42
21	74	97.37	2	2.63	0	0

Figure C-20—ADHS Independent Case Review 2002: NARBHA Adult Non-SMI

NARBHA Adult NSMI	YES		NO		NA	
	N	%	N	%	N	%
Standard						
1	78	88.64	10	11.36	0	0
2	82	93.18	6	6.82	0	0
3a	86	97.73	2	2.27	0	0
3b	20	22.73	14	15.91	54	61.36
3c	33	37.50	3	3.41	52	59.09
4	83	94.32	5	5.68	0	0
5a	10	11.36	1	1.14	77	87.50
5b	2	2.27	0	0	86	97.73
5c	45	51.14	14	15.91	29	32.95
5d	14	15.91	0	0	74	84.09
5e	7	7.95	2	2.27	79	89.77
5f	3	3.41	0	0	85	96.59
6	6	75.00	1	12.50	1	12.50
7	88	100.00	0	0	0	0
8	86	97.73	2	2.27	0	0
9	31	35.23	57	64.77	0	0
10	22	25.00	19	21.59	47	53.41
11	6	6.82	7	7.95	75	85.23
12	11	12.50	2	2.27	75	85.23
13	26	29.55	17	19.32	45	51.14
14	3	3.41	1	1.14	84	95.45
15a	19	21.59	27	30.68	42	47.73
15b	8	9.09	19	21.59	61	69.32
15c	4	4.55	4	4.55	80	90.91
15d	3	3.41	7	7.95	78	88.64
15e	2	2.27	8	9.09	78	88.64
15f	0	0	8	9.09	80	90.91
15g	4	4.55	3	3.41	81	92.05
16	63	71.59	16	18.18	9	10.23
17	61	69.32	17	19.32	10	11.36
18	45	51.14	18	20.45	25	28.41
19	17	19.32	9	10.23	62	70.45
20a	71	80.68	2	2.27	15	17.05
20b	68	77.27	3	3.41	17	19.32
20c	68	77.27	3	3.41	17	19.32
21	86	97.73	2	2.27	0	0

Figure C-21—ADHS Independent Case Review 2002: PGBHA Adult SMI

PGBHA Adult SMI	YES		NO		NA	
	N	%	N	%	N	%
Standard 1	29	87.88	4	12.12	0	0
2	33	100.00	0	0	0	0
3a	32	96.97	1	3.03	0	0
3b	6	18.18	7	21.21	20	60.61
3c	9	27.27	2	6.06	22	66.67
4	33	100.00	0	0	0	0
5a	6	18.18	0	0	27	81.82
5b	1	3.03	0	0	32	96.97
5c	14	42.42	5	15.15	14	42.42
5d	8	24.24	0	0	25	75.76
5e	0	0	1	3.03	32	96.97
5f	1	3.03	0	0	32	96.97
6	2	66.67	0	0	1	33.33
7	33	100.00	0	0	0	0
8	33	100.00	0	0	0	0
9	4	12.12	29	87.88	0	0
10	30	90.91	3	9.09	0	0
11	13	39.39	8	24.24	12	36.36
12	13	39.39	2	6.06	18	54.55
13	22	66.67	11	33.33	0	0
14	0	0	1	3.03	32	96.97
15a	6	18.18	5	15.15	22	66.67
15b	14	42.42	6	18.18	13	39.39
15c	7	21.21	7	21.21	19	57.58
15d	1	3.03	4	12.12	28	84.85
15e	0	0	4	12.12	29	87.88
15f	0	0	0	0	33	100.00
15g	4	12.12	1	3.03	28	84.85
16	24	72.73	9	27.27	0	0
17	25	75.76	8	24.24	0	0
18	31	93.94	2	6.06	0	0
19	16	48.48	2	6.06	15	45.45
20a	31	93.94	0	0	2	6.06
20b	31	93.94	0	0	2	6.06
20c	31	93.94	0	0	2	6.06
21	33	100.00	0	0	0	0

Figure C-22—ADHS Independent Case Review 2002: PGBHA Adult Non-SMI

PGBHA Adult NSMI	YES		NO		NA	
	N	%	N	%	N	%
Standard						
1	107	91.45	10	8.55	0	0
2	111	94.87	6	5.13	0	0
3a	113	96.58	4	3.42	0	0
3b	28	23.93	24	20.51	65	55.56
3c	49	41.88	4	3.42	64	54.70
4	116	99.15	1	0.85	0	0
5a	7	5.98	0	0	110	94.02
5b	3	2.56	0	0	114	97.44
5c	70	59.83	13	11.11	34	29.06
5d	12	10.26	0	0	105	89.74
5e	7	5.98	5	4.27	105	89.74
5f	5	4.27	0	0	112	95.73
6	5	100.00	0	0	0	0
7	116	99.15	1	0.85	0	0
8	116	99.15	0	0	1	0.85
9	37	31.62	80	68.38	0	0
10	51	43.59	26	22.22	40	34.19
11	18	15.38	11	9.40	88	75.21
12	18	15.38	7	5.98	92	78.63
13	40	34.19	38	32.48	39	33.33
14	5	4.27	2	1.71	110	94.02
15a	48	41.03	17	14.53	52	44.44
15b	23	19.66	26	22.22	68	58.12
15c	13	11.11	10	8.55	94	80.34
15d	7	5.98	6	5.13	104	88.89
15e	3	2.56	4	3.42	110	94.02
15f	1	0.85	11	9.40	105	89.74
15g	12	10.26	2	1.71	103	88.03
16	80	68.38	28	23.93	9	7.69
17	79	67.52	29	24.79	9	7.69
18	84	71.79	9	7.69	24	20.51
19	40	34.19	4	3.42	73	62.39
20a	111	94.87	0	0	6	5.13
20b	108	92.31	3	2.56	6	5.13
20c	109	93.16	2	1.71	6	5.13
21	114	97.44	3	2.56	0	0

Figure C-23—ADHS Independent Case Review 2002: ValueOptions Adult SMI

VO Adult SMI	YES		NO		NA	
	N	%	N	%	N	%
Standard 1	83	96.51	3	3.49	0	0
2	77	89.53	9	10.47	0	0
3a	78	91.76	7	8.24	0	0
3b	23	26.74	35	40.70	28	32.56
3c	43	50.59	11	12.94	31	36.47
4	74	90.24	8	9.76	0	0
5a	17	19.77	1	1.16	68	79.07
5b	5	5.88	2	2.35	78	91.76
5c	54	63.53	12	14.12	19	22.35
5d	16	18.82	6	7.06	63	74.12
5e	9	10.47	6	6.98	71	82.56
5f	11	12.79	3	3.49	72	83.72
6	2	66.67	0	0	1	33.33
7	83	96.51	3	3.49	0	0
8	76	89.41	5	5.88	4	4.71
9	14	16.47	71	83.53	0	0
10	55	63.95	28	32.56	3	3.49
11	56	65.12	9	10.47	21	24.42
12	22	25.58	6	6.98	58	67.44
13	58	67.44	27	31.40	1	1.16
14	2	2.33	2	2.33	82	95.35
15a	16	18.60	15	17.44	55	63.95
15b	33	38.37	21	24.42	32	37.21
15c	23	26.74	17	19.77	46	53.49
15d	6	6.98	11	12.79	69	80.23
15e	5	5.81	9	10.47	72	83.72
15f	1	1.16	2	2.33	83	96.51
15g	7	8.24	8	9.41	70	82.35
16	57	66.28	27	31.40	2	2.33
17	50	58.14	34	39.53	2	2.33
18	49	56.98	26	30.23	11	12.79
19	33	38.37	12	13.95	41	47.67
20a	67	77.91	16	18.60	3	3.49
20b	61	70.93	6	6.98	19	22.09
20c	62	72.09	5	5.81	19	22.09
21	79	91.86	7	8.14	0	0

Figure C-24—ADHS Independent Case Review 2002: ValueOptions Adult Non-SMI

VO Adult NSMI	YES		NO		NA	
	N	%	N	%	N	%
Standard 1	69	82.14	15	17.86	0	0
2	65	77.38	19	22.62	0	0
3a	74	88.10	10	11.90	0	0
3b	10	11.90	34	40.48	40	47.62
3c	28	33.33	10	11.90	46	54.76
4	67	79.76	17	20.24	0	0
5a	3	3.57	4	4.76	77	91.67
5b	0	0	4	4.76	80	95.24
5c	34	40.48	18	21.43	32	38.10
5d	2	2.38	4	4.76	78	92.86
5e	11	13.10	9	10.71	64	76.19
5f	4	4.76	4	4.76	76	90.48
6	2	18.18	5	45.45	4	36.36
7	72	85.71	12	14.29	0	0
8	70	83.33	2	2.38	12	14.29
9	6	7.14	78	92.86	0	0
10	26	30.95	34	40.48	24	28.57
11	10	11.90	16	19.05	58	69.05
12	14	16.67	7	8.33	63	75.00
13	32	38.10	20	23.81	32	38.10
14	2	2.38	5	5.95	77	91.67
15a	13	15.48	25	29.76	46	54.76
15b	6	7.14	26	30.95	52	61.90
15c	3	3.57	12	14.29	69	82.14
15d	1	1.19	6	7.14	77	91.67
15e	1	1.19	6	7.14	77	91.67
15f	2	2.38	8	9.52	74	88.10
15g	0	0	6	7.14	78	92.86
16	39	46.43	38	45.24	7	8.33
17	36	42.86	41	48.81	7	8.33
18	31	36.90	28	33.33	25	29.76
19	13	15.48	17	20.24	54	64.29
20a	65	77.38	7	8.33	12	14.29
20b	61	72.62	4	4.76	19	22.62
20c	61	72.62	4	4.76	19	22.62
21	74	88.10	10	11.90	0	0

APPENDIX D. Distribution of Responses by TRBHA

Appendix D contains tables that show the distribution of the responses by TRBHA from the abstracted ICR tool for adults and children.

Table D-1—ADHS Independent Case Review 2002: Pasqua-Yaqui

		Adult		Child	
Standard	MPS	N	Score	N	Score
1	85%	1	100.0%	2	100.0%
2	85%	1	100.0%	2	100.0%
3a	85%	1	100.0%	2	100.0%
3b	85%	0	NA	2	100.0%
3c	85%	1	100.0%	2	100.0%
4	85%	1	100.0%	2	100.0%
5a	80%	1	100.0%	0	NA
5b	80%	0	NA	1	100.0%
5c	80%	1	100.0%	2	50.0%
5d	80%	1	100.0%	1	100.0%
5e	80%	0	NA	0	NA
5f	80%	0	NA	0	NA
6	85%	0	NA	0	NA
7	80%	1	100.0%	2	100.0%
8	80%	1	100.0%	2	100.0%
9	70%	1	100.0%	2	0.0%
10	80%	1	0.0%	1	0.0%
11	70%	1	0.0%	0	NA
12	85%	0	NA	0	NA
13	None	1	0.0%	1	0.0%
14	60%	0	NA	0	NA
15a	60%	1	0.0%	1	0.0%
15b	60%	1	0.0%	0	NA
15c	60%	1	0.0%	0	NA
15d	60%	1	0.0%	1	0.0%
15e	60%	1	0.0%	0	NA
15f	60%	0	NA	0	NA
15g	60%	1	0.0%	0	NA
16	80%	1	100.0%	2	50.0%
17	80%	1	100.0%	2	50.0%
18	70%	1	100.0%	2	50.0%
19	70%	1	100.0%	2	50.0%
20a	80%	1	100.0%	2	100.0%
20b	80%	1	100.0%	2	0.0%
20c	80%	1	100.0%	2	100.0%
21	85%	1	100.0%	2	100.0%

Table D-2— ADHS Independent Case Review 2002: Navajo

		Adult		Child	
Standard	MPS	N	Score	N	Score
1	85%	1	0.0%	1	100.0%
2	85%	1	100.0%	1	100.0%
3a	85%	1	100.0%	1	100.0%
3b	85%	1	100.0%	1	100.0%
3c	85%	0	NA	1	100.0%
4	85%	1	100.0%	1	100.0%
5a	80%	0	NA	0	NA
5b	80%	0	NA	0	NA
5c	80%	0	NA	0	NA
5d	80%	0	NA	0	NA
5e	80%	0	NA	0	NA
5f	80%	0	NA	0	NA
6	85%	0	NA	1	100.0%
7	80%	1	100.0%	1	100.0%
8	80%	1	100.0%	1	100.0%
9	70%	1	0.0%	1	100.0%
10	80%	0	NA	1	0.0%
11	70%	0	NA	0	NA
12	85%	0	NA	0	NA
13	None	0	NA	1	100.0%
14	60%	0	NA	0	NA
15a	60%	0	NA	0	NA
15b	60%	0	NA	0	NA
15c	60%	0	NA	0	NA
15d	60%	0	NA	0	NA
15e	60%	0	NA	0	NA
15f	60%	0	NA	0	NA
15g	60%	0	NA	0	NA
16	80%	1	0.0%	1	100.0%
17	80%	1	0.0%	1	100.0%
18	70%	1	100.0%	1	100.0%
19	70%	1	100.0%	1	100.0%
20a	80%	1	100.0%	1	100.0%
20b	80%	1	100.0%	1	100.0%
20c	80%	1	100.0%	1	100.0%
21	85%	1	100.0%	1	100.0%

Table D-3— ADHS Independent Case Review 2002: Gila River

		Adult		Child	
Standard	MPS	N	Score	N	Score
1	85%	2	50.0%	6	66.7%
2	85%	2	100.0%	6	83.3%
3a	85%	2	100.0%	6	83.3%
3b	85%	1	0.0%	6	83.3%
3c	85%	2	100.0%	6	83.3%
4	85%	2	100.0%	6	83.3%
5a	80%	0	NA	3	66.7%
5b	80%	0	NA	2	50.0%
5c	80%	2	100.0%	6	83.3%
5d	80%	0	NA	2	50.0%
5e	80%	0	NA	3	66.7%
5f	80%	0	NA	2	50.0%
6	85%	0	NA	1	100.0%
7	80%	2	100.0%	6	83.3%
8	80%	2	100.0%	5	100.0%
9	70%	2	50.0%	6	50.0%
10	80%	1	0.0%	4	25.0%
11	70%	0	NA	3	33.3%
12	85%	0	NA	1	0.0%
13	None	1	100.0%	4	50.0%
14	60%	0	NA	1	0.0%
15a	60%	2	0.0%	4	0.0%
15b	60%	1	0.0%	4	0.0%
15c	60%	0	NA	3	33.3%
15d	60%	0	NA	2	0.0%
15e	60%	0	NA	3	0.0%
15f	60%	0	NA	1	0.0%
15g	60%	1	100.0%	2	50.0%
16	80%	2	50.0%	6	66.7%
17	80%	2	50.0%	6	66.7%
18	70%	2	100.0%	6	83.3%
19	70%	1	100.0%	6	83.3%
20a	80%	2	100.0%	6	83.3%
20b	80%	2	100.0%	5	100.0%
20c	80%	2	100.0%	5	100.0%
21	85%	2	100.0%	6	83.3%

APPENDIX E. Standards Aligned with Requirements

Appendix E lists the standards used in the 2002 ICR and the requirements with which they were aligned.

Table E-1—ADHS Independent Case Review 2002: Standards Aligned with Requirements

Standard/Item	JK Principles	Arnold	DDD	AHCCCS Contract	AHCCCS Performance Measure
1. Assessments are sufficiently comprehensive for the development of functional treatment recommendations.	Yes # 5. Best Practices # 8 Services Tailored to Child & Family	Yes	Yes		Yes Sufficiency of assessments
2. The types and intensity of services are provided based upon the needs identified in the individual's assessment and treatment recommendations.	Yes # 4. Accessible Services	Yes	Yes		Yes Appropriateness of services
3. Staff actively engage the following in the treatment planning process: a. Individual b. Family c. Other agencies	Yes # 1. Collaboration with Child & Family # 8. Services Tailored to Child & Family	Yes	Yes		Yes Member/Family Involvement
4. Case management services are provided based on the individual's assessment and treatment recommendations.	Yes # 4. Accessible Services	Yes	Yes	Yes	Yes Appropriateness of service
5. Outreach/follow-up occurs after: a. discharge from inpatient b. discharge from residential c. missed appointments, missed lab d. crisis episodes e. service refusals f. medication refusal.	Yes # 9. Stability	Yes	Yes	Yes Section D.Program Requirements, 14. Outreach & Follow-Up Activities, missed appointments and crisis services	
6. The client has an assigned clinician.	Yes # 5. Best Practices	No	No	Yes Section D.Program	No

Standard/Item	JK Principles	Arnold	DDD	AHCCCS Contract	AHCCCS Performance Measure
				Requirements, 7. Service Delivery, b.	
7. The assigned clinician is actively involved in the oversight of the treatment.	Yes # 5. Best Practices	No	No	Yes Section D.Program Requirements, 7. Service Delivery, b.	No
8. Individuals'/families' cultural preferences are assessed and included in the development of treatment plans.	Yes # 10. Culturally Competent	Yes	No		Yes Cultural competency
9. Individuals and/or parent/guardians are informed about and give consent for prescribed medications.	Yes # 1. Collaboration with Child & Family	Yes	Yes		Yes Informed consent
10. If the individual has been prescribed anti-psychotic medication, regular assessments for movement disorders are documented.	Yes # 5. Best Practices	Yes	Yes	No	No
11. If the individual has been prescribed psychotropic medication and adverse reactions or side effects are noted, progress notes include documentation of follow-up actions to address adverse effects.	Yes # 5. Best Practices	Yes	Yes	No	No
12. If the individual has been prescribed psychotropic medication, the record includes documentation of specific target symptoms.	no	Yes	Yes	No	No
13. The disposition of the referral from the PCP/Health Plan is communicated to the PCP/Health Plan within 30 days of receiving the request for service.	Yes # 3. Collaboration with Others	No	No		Yes Coordination of care contractors/PCPs

Standard/Item	JK Principles	Arnold	DDD	AHCCCS Contract	AHCCCS Performance Measure
14. Behavioral health care has been coordinated with the primary care physician in the following circumstances:					
a. Initiation and significant changes in psychotropic medications and significant adverse reactions;	Yes # 3. Collaboration with Others # 9. Stability (b & c) # 5. Best Practices (e) # 8. Services Tailored..(f)	Yes	No		Yes Coordination of care contractors/PCPs
b. Emergency/crisis admission or events;					
c. Discharge from an inpatient setting;					
d. Disenrollment from ADHS/RBHA;					
e. Initial assessment and treatment recommendations;					
f. Results of relevant laboratory, radiology and other tests;					
g. Any other events requiring medical consultation with the member's PCP.					
15. There is evidence of symptomatic improvement.	Yes # 2. Functional Outcome Based	Yes	Yes		Yes Quality Clinical Outcomes
16. There is evidence of functional improvement.	Yes # 2. Functional Outcome Based	Yes	Yes		Yes Quality Clinical Outcomes
17. Service plans and/or services are revised based on progress or lack of progress in the client's behavioral health condition.	Yes #2. Functional Outcome Based	Yes	Yes		Yes Quality Clinical Outcomes
18. Service plans and/or services are revised based on significant changes in the individual's behavioral health condition.	Yes #2. Functional Outcome Based	Yes	Yes		Yes Quality Clinical Outcomes
19. Services are provided in a timeframe responsive to the urgency of the member's need.	Yes # 4. Accessible Services	Yes	Yes		Yes Access to Care

APPENDIX F. Abstraction Tool

Appendix F contains the scannable form that HSAG used as an abstraction tool.

Independent Case Review (ICR)
ADHS/DBHS 2002

HSAG HEALTH SERVICES ADVISORY GROUP

MMWWMMMWWW

FK

1/17/2003 F

Review Period: *April 1, 2002 through Dec. 31, 2002 - Fill in appropriate bubble if answer is Yes, No, or N/A .*

Last Name:	**Individual ID#:**	*If DOB is different, fill in the boxes below.*
First Name:	**DOB:**	☐☐ / ☐☐ / ☐☐☐☐

If any of the following apply, fill in the bubble, stop the abstraction, and consult the project manager.

○ **No data in measurement year** ○ **Inpatient data only** ○ **No valid reason** ○ **Disenrolled** ○ **Deceased**

○ **Only encounter during 1st quarter** ○ **Individual incarcerated** ○ **Residential only** ○ **Moved** ○ **Other**

Standard

1) Assessments are sufficiently comprehensive for the development of functional treatment recommendations. ○ Yes ○ No

2) The types and intensity of services are provided based upon the needs identified in the individual's assessment and treatment recommendations. ○ Yes ○ No

3) Staff actively engage the following in the treatment planning process:

a. Individual **a** ○ Yes ○ No

b. Family **b** ○ Yes ○ No ○ N/A

c. Other agencies **c** ○ Yes ○ No ○ N/A

4) Case management services are provided based on the individual's assessment and treatment recommendations. ○ Yes ○ No

5) Outreach/follow-up occurs after:

a. discharge from inpatient **a** ○ Yes ○ No ○ N/A

b. discharge from residential **b** ○ Yes ○ No ○ N/A

c. missed appointments **c** ○ Yes ○ No ○ N/A

d. crisis episodes **d** ○ Yes ○ No ○ N/A

e. service refusal **e** ○ Yes ○ No ○ N/A

f. medication refusal **f** ○ Yes ○ No ○ N/A

6) FOR DDD MEMBERS ONLY: Individuals with identified specialized service needs are referred for and receive these services. ○ Yes ○ No ○ N/A

7) The individual has an assigned clinician. ○ Yes ○ No

8) The assigned clinician is actively involved in the oversight of the treatment. ○ Yes ○ No ○ N/A

9) Individuals'/families' cultural preferences are assessed and included in the development of treatment plans. ○ Yes ○ No

10) Individuals and/or parent/guardians are informed about and give consent for prescribed medications. ○ Yes ○ No ○ N/A

11) If the individual has been prescribed anti-psychotic medication, regular assessments for movement disorders are documented. ○ Yes ○ No ○ N/A

12) If the individual has been prescribed psychotropic medication and adverse reactions or side effects are noted, progress notes include documentation of follow-up actions to address adverse effects. ○ Yes ○ No ○ N/A

13) If the individual has been prescribed psychotropic medication, the record includes documentation of specific target symptoms. ○ Yes ○ No ○ N/A

14)	The disposition of the referral from the PCP or Health Plan is communicated to the PCP or Health Plan within 30 days of receiving the request for service.	○ Yes	○ No	○ N/A
15)	Behavioral health care has been communicated or attempts have been made to coordinate with the PCP in the following circumstances:			
	a. initial assessment and treatment recommendations	**a** ○ Yes	○ No	○ N/A
	b. initiation and significant changes in psychotropic medications and significant adverse reactions	**b** ○ Yes	○ No	○ N/A
	c. results of relevant laboratory, radiology and other tests	**c** ○ Yes	○ No	○ N/A
	d. emergency/crisis admission or events	**d** ○ Yes	○ No	○ N/A
	e. discharge from an inpatient setting	**e** ○ Yes	○ No	○ N/A
	f. disenrollment from ADHS/RBHA	**f** ○ Yes	○ No	○ N/A
	g. any other events requiring medical consultation with the individual's PCP	**g** ○ Yes	○ No	○ N/A
16)	There is evidence of symptomatic improvement.	○ Yes	○ No	○ N/A
17)	There is evidence of functional improvement.	○ Yes	○ No	○ N/A
18)	Service plans and/or services are revised based on progress or lack of progress in the individual's behavioral health condition.	○ Yes	○ No	○ N/A
19)	Service plans and/or services are revised based on significant changes in the individual's behavioral health condition.	○ Yes	○ No	○ N/A
20)	The treatment plan: **(If 20a is answered N/A or No, 20b and 20c must be answered N/A)**			
	a. incorporates the identified needs of the individual	**a** ○ Yes	○ No	○ N/A
	b. includes measurable goals which address those needs	**b** ○ Yes	○ No	○ N/A
	c. describes specific action steps to reasonably accomplish the goals	**c** ○ Yes	○ No	○ N/A
21)	Services are provided in a timeframe responsive to the urgency of the member's need.	○ Yes	○ No	
22)	Positive for pregnancy.	○ Yes		
23)	Positive for IV drug use.	○ Yes		

Comments: _____

Reviewer ID# ☐☐☐

Review Time: (minutes) ☐☐☐

Review Date: ☐☐ / ☐☐ / 2003

G. Instructions for Using Abstraction Tool

Appendix G contains instructions for using the abstraction tool.

INDEPENDENT CASE REVIEW
Instructions
FINAL 011003

The items below correspond to the draft Independent Case Review Tool. The study period is 04/01/02 through 12/31/02.

1. To qualify as a sufficiently comprehensive assessment, the clinician must be able to identify and develop functional treatment recommendations based upon the assessment. If no formal assessment is located, look for the most recent psychiatric and nursing evaluations. If none found, look for the most recent psychosocial and functional assessments. If none found, look for the most recent staffing and psychiatric prescriber progress notes. If no formal assessment is found, you may use up to four of the most recent documents. Using clinical judgment, make a determination if the assessment or assessments (up to 4) include enough information to identify and prioritize the services the person needs to meet their behavioral health needs. An ALFA or other functional test evaluation can contribute to the assessment information but cannot stand-alone. Components of a comprehensive assessment/assessments should include whether further assessment is needed, if the member has a substance abuse history, a co-occurring disorder, medication history, medical history, legal history, criminal justice history, family history, treatment history including court ordered evaluation and court ordered treatment. If the assessment or assessments contain the needed information, answer YES. If not, answer NO. A rating of NA is not permitted.

2. After review of the assessment information, including recommendations from the psychiatrist, nurse and/or other treating providers, the person's most recent treatment/service plan should be reviewed to determine whether the services provided, including specialized services, are consistent with the needs identified in the assessments. The review should evaluate both the type of service and frequency of service provision. All needs identified in the treatment/service plan must be addressed to qualify for a YES answer. If none are identified or only some of the needs that are identified in the treatment/service plan are-addressed, mark answer NO. A rating of NA is not permitted.

3. If, in the treatment planning process, there is evidence that staff have made efforts to actively engage the individual, involved family members/significant others, or other involved parties/agencies in the treatment planning process, answer YES. If there is evidence that these individuals would have an impact on treatment planning but there is no evidence of staff efforts to engage them, the reviewer will check the NO box assigned to the designated person (individual, family/significant other, other agencies). Answer NA for 3b and 3c if there are no family/significant others or other agencies. Since an adult member has to give permission for other involved parties or family members to participate in treatment planning, this should be considered when

deciding who should have been involved. For individuals with multi-agency involvement, there should be evidence for each agency identified that staff actively attempted to engage their participation and that their input was considered in the development of the treatment/service**.** For each person or agency designated, evidence of active engagement includes verbal or written efforts to solicit their input.

For a child or adult DDD Member, the DDD Support Coordinator must be involved in the treatment planning process. A child's parent or guardian must also be involved. The DDD adult member and his/her guardian (if applicable) must also be involved in the treatment planning process.

For individuals with multiple agency involvement, if evidence of active engagement to solicit input from **all** designated parties is present, answer YES. If no evidence of active engagement, or that only **some** of the designated parties were solicited for input, answer NO.

4. Review the case management services as related to the needs identified in the assessment and treatment recommendations. If the member is receiving case management services with sufficient frequency to implement the treatment plan recommendations or clear attempts are being made to engage the individual or adjust the plan as necessary, answer YES. If no evidence is present, answer NO. For individuals who are capable of managing their own services, case management services may not be necessary. If the member does not appear to need case management services and was not receiving services, answer YES. All components of the treatment plan that pertain to case management must be implemented or in the process of adjustment to qualify as a YES answer. A rating of NA is not permitted.

5. Outreach/follow-up occurs after each:

    5a. If the person was not discharged from an inpatient setting, answer N/A. Or if after discharge there is not sufficient time to measure follow-up before the end of the review year, answer NA. If the person was discharged from an inpatient setting, review the inpatient discharge planning documentation as well as post-discharge documentation (progress notes, treatment/service plans, clinical team meeting/staffing notes) to determine if outreach/follow-up occurred after discharge from an inpatient setting. Outreach/follow-up activities may include telephonic, written contact or home visits. If documentation is present, answer YES. If no evidence of follow up is present, answer NO.

    5b. If the person was not discharged from a residential setting or if there is not sufficient time in the review year to measure follow-up after a discharge, answer NA. If the person was discharged from a residential setting, review the residential discharge planning documentation as well as post-discharge documentation (progress notes, treatment/service plans, clinical team meeting/staffing notes) to determine if outreach/follow-up occurred after

discharge from a residential setting. Outreach/follow-up activities may include telephonic, written contact or home visits. If documentation is present, answer YES. If no evidence of follow up is present, answer NO.

5c. Review the service/treatment plan to ascertain the frequency of clinic appointments for the person. After reviewing progress and staffing notes, the reviewer will make a determination 1) if any appointments were missed and 2) if outreach/follow-up occurred after any missed appointments. Outreach/follow-up activities may include telephonic, written contact or home visits. If no clinic or other appointments were missed, answer N/A or if there is not sufficient time in the review year, to measure follow-up after a missed appointment, answer NA. If there were missed appointments and evidence of follow up is present, answer YES. If not, answer NO. If more than one appointment was missed, follow-up must occur after each missed appointment to qualify for a YES answer.

5d. Review the progress notes. If the notes indicate that the person had a crisis episode, determine if outreach/follow up occurred after the episode. Outreach/follow-up activities may include telephonic, written contact or home visits. If it did, answer YES. If not, answer NO. If the notes indicate that the person did not have a crisis episode, answer NA or if there is not sufficient time in the review year, to measure follow-up, answer NA. If there is more than one crisis episode, follow-up must occur after each episode to answer YES. Crisis means admission to an urgent care center or hospital or an event requiring emergency intervention.

5e. Review the progress notes. If the notes indicate that the person refused a service, determine if outreach/follow up occurred after the refusal. If it did, answer YES. If not, answer NO. If there is no indication in the progress notes that the person refused a service, answer NA or if there is not sufficient time in the review year, to measure follow-up, answer NA. Outreach/follow-up activities may include telephonic, written contact or home visits. If a person refused a service more than once, follow-up must occur after each refusal to qualify for a yes answer.

5f. Review the progress notes. If the person was not prescribed medication, or prescribed medication but takes the medication answer NA or if there is not sufficient time during the review year for follow-up, answer NA. If documentation indicates the person refused to take the medication and outreach/follow-up efforts occurred, answer YES. Outreach/follow-up activities may include telephonic, written contact or home visits. If no outreach efforts occurred answer NO. If medication was refused more than one time, follow-up must occur after each refusal to count as a YES answer.

6. This question is answered only for individuals with a developmental disability who are also served by DES/DD. Review the assessments/evaluations, orders,

treatment/service plan, and progress notes. Determine if any unique needs are identified relating to their developmental disabilities, such as:

- behaviors that would require individually-tailored behavioral management programs,
- the need for therapeutic accommodations for deficient language skills,
- complex family, social or community issues that speak to the need for person-centered planning or the development of a child/family team,
- sensory impairments that would require an aid or interpreter.

If unique needs are not present, answer N/A. If present, determine if they are addressed in the service/treatment plan. If not, answer NO. If specialized services are listed on the treatment plan, progress notes should indicate that the person was referred to and received those services. If not, answer NO. If so, answer YES. To qualify for a YES answer, the need must be identified on the treatment/service plan, referred to the appropriate provider, and the member must have received the designated service.

7. Review the person's clinical record including the demographic information (e.g. FACE Sheet) to verify evidence that an Assigned Clinician has been identified. NA is not permitted.

8. An Assigned Clinician is a behavioral health clinician who serves as a fixed point of accountability to ensure active treatment and continuity of care between providers, settings and treatment episodes. The Assigned Clinician may provide active treatment or ensure that treatment is provided to enrolled persons. Progress/contact notes, staffing notes and treatment/services plans should be reviewed to determine whether there is evidence that the assigned clinician is providing clinical oversight and facilitating decision-making regarding the member's behavioral health care. Answer NO if there is only a designation of a person as the Assigned Clinician without any evidence of their involvement in the activities described above. Answer YES if it is evident that the Assigned Clinician is playing an active role. Answer NA if # 7 was answered NO.

9. Review the person's identifying information and the assessments/evaluations**.** If there is an indication that the individual's or family's cultural preferences were assessed, considered and incorporated into the individual's treatment recommendations, answer YES. If not, answer NO. If the individual or family's cultural preferences were assessed but not incorporated into the treatment/service/plan the answer is NO. A rating of NA is not permitted.

10. Evidence that the member and or legal guardian provided either verbal or written consent to take prescribed psychotropic medications can be located in the progress notes of the physician or nurse practitioner, on consent forms, or in treatment team meeting notes.

A YES answer indicates that there is written documentation that the member or legal guardian gave informed consent. If the record indicates that the member has a formal legal guardianship established, or the member is a child (under age 18 years), the parent or legal guardian if other than the parent must provide the informed consent.

A NO answer indicates that the member or legal guardian either did not provide verbal or written consent, or that despite having documentation of an established legal guardianship, there is no documentation that informed consent was provided by that legal guardian. A NO answer would also be given if the member or legal guardian provided verbal or written consent for some, but not all of the psychotropic medications.

Answer NA if the individual is not being prescribed to take any psychotropic medications.

11. Review the person's file and if the person is not taking an anti-psychotic medication answer N/A or if there is not sufficient time during the review year for follow-up, answer NA. If the person is on medication and there is no indication of assessment for movement disorders, enter NO. If the record indicates an assessment for a movement disorder or AIMS test was administered at baseline, with a change of medication, or annually, enter YES.

12. Review the person's file and if the person has not been prescribed psychotropic medication answer N/A. If the person is on psychotropic medication and there is no indication of side effects or adverse reaction, answer N/A. If the file indicates side effects or other adverse reaction and actions have been taken to address the adverse effect of the medication, then answer YES. If no actions have been taken to address the adverse reaction to the medication answer NO.

13. Review the documentation, including psychiatric and nursing progress notes, treatment/service plans and psychiatric evaluations to determine whether the specific symptom(s) or indication(s) for which the medications are being prescribed is documented. If the target symptom or symptoms, for each regularly scheduled medication, are documented, answer YES. If there is no documentation of the symptom(s), answer NO. Answer NA only if the member is not prescribed psychotropic medication.

14. Review the documentation for a verbal referral or a hard copy referral from the PCP/Health Plan regarding behavioral health needs for an individual. If there is not a request, answer NA. Answer YES, if documentation is located indicating that the behavioral health provider has communicated to the PCP/health plan regarding the disposition of the referral within 30 days of the request for service. Answer NO, if there was a request and documentation is not located or if the disposition was dated

greater than 30 days after the request for referral. If a disposition is located without a request or referral date, answer N/A.

15. Review the documentation and determine if evidence exists of ensuring the behavioral health records and other relevant information is shared with the individual's PCP when the following circumstances occur. Answer YES if documentation is present and answer NO if there is no document for each category. If a member is Non-Title XIX or Non-Title XXI and does not have a PCP, answer NA.

    15a. Answer YES if the person has been in treatment less than one year and there is documentation of communication or attempts to coordinate with the PCP regarding an initial assessment and treatment recommendations. Answer NO if there is no documentation of communication or attempts to coordinate with the PCP. NA is not allowed unless the member has been in treatment more than one year or if the person is Non-TitleXIX/XXI.

    15b. Answer YES if there is documentation of communication or attempts to coordinate with the PCP regarding initiation and significant changes in psychotropic medications and significant adverse reactions. Answer NO if there is no documentation of communication or attempts to coordinate with the PCP. Answer NA if the person has not been prescribed psychotropic medication or there has not been any significant changes or adverse reactions in the time period examined or the person is a Non-Title XIX/XXI member. Significant, means a different class of medications or an adverse reaction requiring treatment or stopping the medication.

    15c. Answer YES if there is documentation of communication or attempts to coordinate with the PCP regarding results of relevant laboratory, radiology and other test. Answer NO, if there is no documentation of communication or attempts to coordinate with the PCP. Use NA if no relevant test or non-Title XIX member. Relevant means any test results that would require follow up or treatment by the PCP or any results that may impact the member's medical care.

    15d. Answer YES if there is documentation of communication or attempts to coordinate with the PCP regarding emergency/crisis admission or events. Answer NO if there is no documentation of communication or attempts to coordinate with the PCP. Use NA if no admission had occurred or non-Title XIX member. Crisis means admission to an urgent care center or hospital or an event requiring emergency intervention.

    15e. Answer YES if there is documentation of communication or attempts to coordinate with the PCP regarding discharge from an inpatient setting. Answer NO if there is no documentation of communication or attempts to

coordinate with the PCP. Answer NA if a discharge had not occurred or non-Title XIX/XXI member.

15f. Answer YES if there is documentation of communication or attempts to coordinate with the PCP regarding disenrollment from ADHS/RBHA. Answer NO if there is no documentation of communication or attempts to coordinate with the PCP. Answer NA if there has been no disenrollment or the member is non titleXIX/XXI.

15g. Answer YES if there is documentation of communication or attempts to coordinate with the PCP regarding other events requiring consultation with the PCP. Answer NO if there is no documentation of communication or attempts to coordinate with the PCP. For Division of Developmental Disabilities (DDD) members, with co-occurring medical conditions, consultations with the primary care physician must be documented. Use NA only if in the judgment of the reviewer, no other events occurred that required communication or attempts to coordinate with the PCP based upon the review of the member's case file or Non-Title XIX/XXI member.

16. Review the progress notes, assessment information, service/treatment plan, psychiatric and nursing progress notes to determine whether there is evidence that services provided to the individual produced symptomatic improvement. (i.e. decreased hallucinations, mood swings, harmful behaviors, substance abuse, etc.). To qualify for a YES answer, there may be improvement in ANY of the symptoms or the individual remained stable. To answer NO, there will be no improvement or there will documentation of a worsening or a regression in symptomatic improvement. You may answer NA if services provided are recent and there is no change in symptoms or if there is not sufficient time in the review period for the reviewer to determine effect.

17. Review the progress notes, assessment information, service/treatment plan, psychiatric and nursing progress notes to determine whether there is evidence that services provided to the individual produced functional improvement. (ie; improved job or school performance, ability to perform activities of daily living, increased social activities, improved interpersonal relationships, etc.) To qualify for a YES answer, there may be ANY functional improvement. If there is no improvement or a worsening of symptoms, answer NO. You may answer NA if services provided are recent and there is no change in function or there is not sufficient time in the review period for the reviewer to determine effect.

18. Review the treatment/service plans to determine if the service plans and/or services are revised based on progress or lack of progress in the individual's behavioral health condition. If documentation of review and or revision in relation to progress status is present, answer YES. If no documentation is located regarding review and or revision of the service plan or services in relation to progress status, answer NO.

Answer NA if there is not sufficient time in the review period to measure progress status.

19. Review the treatment/service plans to determine if the service plans and/or services are revised based on significant worsening or improvement of the individuals behavioral health condition. If there are no significant changes related to the individual's behavioral health condition, answer NA. If documentation of review and or revision is present in relation to significant worsening or improvement of the individuals behavioral health condition, answer YES. If there was significant worsening or significant improvement in the individual's behavioral health condition so that the plan was now irrelevant but there were no revisions to the service plans and/or services, answer NO.

20. The treatment plan includes:

    20a. Review the treatment/service plan and decide if the identified needs of the individual are incorporated into the plan. If there is no treatment/service plan in the record, answer NA. If no identified needs are incorporated answer NO. If identified needs are incorporated in the plan, answer YES. If 20a is answered NO or NA, 20b and 20c will be answered NA.

    20b. Review the treatment/service plan for measurable goals, which address the identified needs. If no measurable goals are present or if there is no treatment/service plan, answer NO. If goals are present, review to determine whether the goals address the identified needs in the treatment/service plan. If the goals both address the identified needs and are measurable, answer YES. If the goals are present but not measurable, or do not address identified needs, answer NO. If 20a is answered NA or NO, 20b must be answered NA.

    20c. Review the treatment/service plans for action steps that are based on the goals. Action steps are the specific methods or means that are needed to obtain the goals. If there are specific action steps identified in order to accomplish the goals, answer YES. If there are no specific action steps identified in order to accomplish the goals, answer NO. If 20a or 20b is answered NA or NO, 20c must be answered NA.

21. Were treatment services provided in a time frame responsive to the urgency of their need? For example, conditions requiring emergency response/attention may include acute withdrawal, acute psychotic symptoms that present an imminent risk with suicidal or homicidal ideation with intent, plan or means or an acute change in behavioral symptoms such as increased aggression or behavioral changes with imminent risk of loss of job, home, or property destruction, etc. Urgent response/attention (within 24 hours) may include missed medication appointments for individuals who rapidly de-compensate without medications, acute intoxication and suicidal or homicidal ideation without intent, plan or means or early warning signs of decompensation. Review assessments, MD/NP notes, progress and staffing

notes. If services were provided in an appropriate timeframe, answer YES. If services were not provided in an appropriate timeframe, answer NO. N/A is not permitted.